BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
RICHARD B. KIM, M.D.	)	Case No. 800-2013-000428
Physician's and Surgeon's Certificate No. G84650	)	OAH No. 2017060854
Respondent	)	

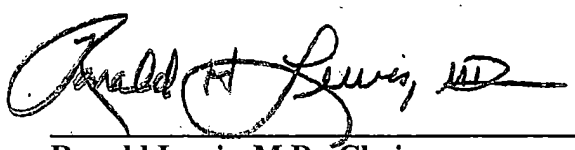
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 3, 2019.

IT IS SO ORDERED: December 4, 2018.

MEDICAL BOARD OF CALIFORNIA



Ronald Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: RICHARD B. KIM, M.D., Physician's and Surgeon's Certificate Number G 84650, Respondent.	Case No. 800-2013-000428 OAH No. 2017060854

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on January 3, 4, 8, 11, and 16, March 6, 7, and 9, and May 9, 10, and 11, 2018, in Los Angeles.

Beneth A. Brown, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

John D. Harwell, Attorney at Law, represented respondent Richard B. Kim, M.D.

During the hearing, complainant moved at various times to amend the First Amended Accusation, as follows: (i) amend paragraph 58 by changing "On or about April 5, 2012" to "On or about April 3, 2012"; (ii) amend paragraph 73, subparagraph (a), by changing "postoperative" to "intraoperative"; (iii) delete subparagraph (a) of paragraph 100; and (iv) delete subparagraph (a) of paragraph 121. There was no objection, and the motions were granted.

Oral and documentary evidence was received. The record was held open to allow post-hearing motions, and to allow the parties to file closing briefs by August 10 and reply briefs by August 24, 2018. At the parties' request, the ALJ ordered the briefing deadlines extended several times; the last orders issued required closing briefs to be filed by September 5, 2018, and reply briefs to be filed by October 3, 2018. Complainant and respondent timely filed closing briefs, marked for identification respectively as exhibits 76 and Q, and reply briefs, marked for identification respectively as exhibits 77 and R.

The record was closed and the matter was submitted on October 3, 2018.

Protective Order

Complainant moved for a protective order sealing exhibits to protect confidential information concerning third parties; respondent made no objection. The ALJ issued a protective order. Redaction of those documents subject to the protective order, to obscure confidential information, was not practicable and would not have provided adequate privacy protection. Those exhibits shall remain under seal and shall not be opened, except by order of the Board, by OAH, or by a reviewing court. The ALJ ordered that every court reporter refer in the hearing transcript to respondent's patients by initials only.

SUMMARY

Complainant seeks to discipline respondent's medical license on grounds of alleged gross negligence, repeated negligent acts, dishonest acts and false medical records, inadequate and inaccurate recordkeeping, and unprofessional conduct in connection with care and treatment provided to seven patients. Respondent denies the allegations and asserts cause for discipline does not exist.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the First Amended Accusation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician's and Surgeon's Certificate No. G 84650 to respondent on June 26, 1998. Respondent's certificate was in full force and effect until November 30, 2017, the last scheduled expiration date for which supporting evidence was submitted.[1] Respondent's medical certificate has not been disciplined.

3. Respondent received his medical degree in 1990 from St. Louis University School of Medicine. Following graduation, respondent completed an internship and a residency neurosurgery at in the Department of Neurosurgery at the New York University Medical Center, and a fellowship in epilepsy surgery in the Department of Neurosurgery at Yale University School of Medicine. Respondent is a Diplomate of the American Board of Neurological Surgery and is a member of the American Association of Neurological Surgeons. He is the medical co-director of DISC Spine and Sports and is an Assistant

[1] The Board retains jurisdiction to discipline expired certificates. (Bus. & Prof. Code, § 118, subd. (b).)

Clinical Professor in the Department of Neurological Surgery at the University of California, Irvine.

Expert Witnesses

4. Complainant called Vrijesh S. Tantuwaya, M.D. as an expert witness. Dr. Tantuwaya received his medical degree from Washington University School of Medicine in 1996. He completed a six-year residency, beginning at Washington University, then continuing at the University of South Carolina, which was less academically-oriented but offered a fellowship without requiring academic research. He is board-certified by the American Board of Neurological Surgery. He is engaged in performing spine surgeries and performing independent utilization review. Dr. Tantuwaya testified that he has performed about 500 fusions; 15 percent of those involved multi-level fusion, and he has placed thousands of pedicle screws.

5. Respondent called three expert witnesses.

6. Bruce M. McCormack, M.D., received his medical degree from the Columbia University College of Physicians and Surgery in 1986, and he completed an internship in general surgery at Mount Sinai Hospital and a residency in neurological surgery at New York University Medical Center in 1992. He was a spine fellow and neurosurgery clinical instructor at the University of Florida and the University of New Mexico, and he was the Director of the University of California, San Francisco, Neuro-Spinal Surgery Service and Assistant Professor of Neurosurgery. Dr. McCormack is board-certified by the American Board of Neurological Surgery since 1998. He is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. He has won research awards and is widely published. Dr. McCormack is engaged in the practice of spine surgery; he has performed 300 to 400 spinal surgeries each year for 20 years, and he has published in the areas of spinal fusion, implants, and the use of cages and screws.

7. Robert S. Bray, Jr. M.D., received his medical degree from Baylor College of Medicine in 1980. He completed a flexible surgical internship and a neurosurgery residency at Baylor Affiliated Hospitals, where he was chief resident. He is a founding director and chief executive officer of the Diagnostic and Interventional Sports & Spine Center. He has served as medical director of Saint John's Spine Institute, and he was a founding director of the Institute for Spinal Disorders at Cedars-Sinai Medical Center. Dr. Bray is a diplomate of the American Board of Neurological Surgery and is a member of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the North American Spine Society. He is widely published in scholarly journals.

8. Michael L. Levy, M.D., Ph.D., received his medical degree from the University of California, San Francisco, School of Medicine in 1986. He completed a residency at the University of Southern California, and a fellowship in pediatric neurosurgery at Children's Hospital of Los Angeles. He is a fellow of the American College of Surgeons and is certified by the American Board of Neurological Surgery and the American Board of Pediatric Neurological Surgery. He has served as a clinical instructor and assistant professor

of neurological surgery at the University of Southern California, and he has staff privileges at the University of California, San Diego, Rady Children's Hospital of San Diego. He serves on the editorial boards of numerous scholarly publications and has published widely.

Patient J.C.[2] *and Expert Testimony*

9. Patient J.C. was 60 years old, with back pain and radicular leg pain (pain radiating from the spine down the distribution of the impinged nerve). Respondent performed a laminectomy and an L3-4 and L4-5 fusion, and an L5-S1 fusion.

10. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence and repeated negligent acts, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient J.C. in that he "(a) performed a spinal fusion without clear and documented indications; (b) used DuraSeal dural sealant in spinal surgery in an FDA off label and highly unusual manner; and (c) failed to expeditiously recognize and treat the malposition of a pedicle screw." (Ex. 1, First Amended Accusation, ¶ 25; see also ¶¶ 108, 127, and 129.)

11. Dr. Tantuwaya testified that, generally, spinal fusion, joining two vertebral segments together to prevent relative movement, is indicated in patients with severe degenerative spinal disease resulting in instability, in patients where the surgeon will be doing a wide laminectomy, removing part of a spinal joint that maintains stability while performing a decompression to take the pressure off the nerves, where the patient has discogenic back pain and the surgeon must remove the disc, or where the patient has severe stenosis of the neural foramen. (Ex. 15, p. 4, medical issue 1.) Instability is commonly found in elderly patients; it can be asymptomatic, or it may involve symptoms including back pain or leg pain. To perform a decompression in the lumbar spine, the surgeon generally approaches from behind, performing a laminectomy (removing a portion of bone in the back part of spine, the lamina). In fusion, the surgeon joins two vertebral segments together to prevent relative movement. First the surgeon must prepare the bony elements by decortication (removing the outer cortex of the bone); next, the surgeon takes bone from another source and lays it down to bridge the two segments of bone, eventually forming a solid segment of bone. This can take three months to a year to form.

12. Patient J.C. had several surgeries. In connection with his first surgery, the stated indications were symptoms of neurogenic claudication, i.e., nerve root compression in the lumbar spine, exacerbated by walking, relieved by sitting, and associated with spinal stenosis. Dr. Tantuwaya testified that, after conservative treatment failed, those were appropriate indications to perform decompression surgery, given the indications, but were not clear indications for performing a fusion. In the first surgery, on January 11, 2011, Patient J.C. underwent a decompression and fusion with instrumentation at L3-4.

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[2] Initials have been used for all patients to protect their confidentiality.

13. Patient J.C. had neurogenic claudication, a symptom complex consistent with nerve impingement. But respondent made no abnormal physical exam findings, so an exam component that fits with the symptoms was lacking. Also, no imaging records leading to that surgery were ever provided. In respondent's medical records, Dr. Tantuwaya found none of the preoperative imaging, i.e., no MRI of the lumbar spine, to support this procedure on January 11, 2011. Diagnostic data showed, at L3-4 and L4-5, moderate stenosis with bilateral foraminal encroachment, L5-S1 degenerative disease, and spondylosis, with moderate to severe foraminal encroachment. Though it is clear respondent was referencing an imaging study, his records do not identify the study, a deviation from the standard of care. Respondent documented his impressions: neurogenic claudication symptoms, degenerative lumbar changes stenosis at two levels, and spondylosis, after a long history of back pain. Dr. Tantuwaya opined that this was insufficient to justify the decompression surgery. Moreover, Dr. Tantuwaya cannot discern why respondent operated on L3-4 but not L4-5. And respondent performed a fusion, but there is nothing in respondent's records to justify fusion, i.e., there is no indication that the patient was unstable or that respondent would do such a wide laminectomy that he would render the patient unstable, or that Patient J.C.'s back pain had a discogenic origin.

14. Dr. Tantuwaya opined that respondent improperly used DuraSeal in two surgeries, on August 22 and August 27, 2013. DuraSeal is normally used to prevent spinal fluid leakage when there is a tear in the dura, a covering around spinal cord and nerve roots that holds spinal fluid. Respondent claimed in his operative report that he used DuraSeal as adhesive in bone grafting during fusion. This is not an FDA-approved use and is not common practice in the community of neurosurgeons. While products may be used off-label, i.e., not endorsed by the FDA, there must be a reasonable justification. Here, respondent engaged in an extreme departure from the standard of care, using DuraSeal off-label in an unconventional, unusual, and risky manner, because the sealant absorbs fluid and can swell, causing neural dysfunction. His use of the product implies a spinal fluid leak, but there was no mention of a leak in the records. Only later did Patient J.C. present with such a leak.

15. On August 22, 2013, respondent performed a second surgery. A July 12, 2013 MRI showing disc degeneration did not support fusion because, for one reason, there was no indication of instability. During surgery, respondent mis-positioned a pedicle screw. The standard of care is to obtain x-rays during surgery, anterior/posterior (AP) and lateral, to make sure the screws are correctly positioned. The problem became apparent when the patient complained of a new pain consistent with a nerve injury right after surgery; if the patient had not complained, there would have been no reason to take the patient back to surgery. This should have prompted an immediate review of the intraoperative imaging, but respondent did not perform such a review. Two days after surgery, on Saturday, August 24, a CT scan was performed; the scan showed the pedicle screw misplaced. But respondent did not perform revision surgery until Tuesday, August 27, an inexcusable delay and an extreme departure from the standard of care and an urgent situation if the patient was in distress. The risk of delay was permanent nerve injury to the L4 or the S1 nerve roots. Dr. Tantuwaya could not ascertain from the records the reason for the passage of three days from the CT scan before respondent performed revision surgery.

16. Dr. Bray testified that justification for spinal fusion is a complex issue widely debated by neurosurgery boards, and that there are no definitive guidelines and no accepted standard. Even the definition of instability varies in insurance company guidelines, though the standard of care is not determined by insurance companies, but by surgeons and surgical societies. Dr. Bray looks at such criteria as instability, back pain, overall alignment and status of spine, collapse, relative success rates of possible procedures, and others in determining whether to perform fusion. It is a field without guaranteed outcomes and with high complication rates.

17. Dr. Bray testified that it is not a departure from the standard of care for a spine surgeon to rely on the report of a qualified radiologist rather than to read the x-ray images himself or herself; the radiologist has a higher level of expertise at interpreting images. In the operating room, the surgeon will see digital fluoroscopic images that may not be read by a radiologist for some time, so the surgeon must assess the images during the procedure. Those images are not of the highest quality, and there is a significant misinterpretation rate, explaining the high national rate of misplaced screws. The standard image is fluoroscopic; intraoperative CT scans are rare. To place a screw, the surgeon must rely on fluoroscopy, evoked electrical potentials, and tactile sense. The literature shows that 5 to 25 or 30 percent of screws are misplaced, due to imperfect imaging; that is one of the risks of surgery. Dr. Bray testified he has installed hundreds of pedicle screws, and he has misplaced screws. If he discovers the misplacement intraoperatively, he repositions the screw, but most misplacements are found by postoperative CT scan. Most do not pose a risk of harm; the literature states that, absent a risk of harm, the surgeon should leave the screw where it is and monitor the patient to see whether the fusion succeeds. If screw irritates or potentially damages a nerve, that is a classic indication for revision of the screw. Only a small percentage requires revision. Fusions are successful between 50 and 90 percent of the time; regardless of whether there is a departure from the standard of care, there is a significant likelihood of failure.

18. Dr. Bray testified that he could not ascertain from one of two intraoperative x-ray images that the screw was misplaced. A second image does clearly show the misplacement.

19. Dr. Bray testified that literature about off-label uses of DuraSeal shows that the product can be used as a sealant to prevent overgrowth of the bone grafted in fusion surgery. Doctors must assess risks and benefits before using any product off-label and must discuss that with the patient for informed consent.

20. Dr. McCormack testified that fusions can be adjunctive to laminectomies; they can improve results, stiffen the spine, and decrease neurologic symptoms. Respondent's notes provided sufficient justification for a laminectomy and fusion.

21. Respondent's use of DuraSeal was not inappropriate. Putting a bone graft from a posterior approach, removing lamina, and working between nerves can result in a small leakage of fluid; DuraSeal will prevent leaks. Its use is contraindicated for spine surgery only

if used in a confined space, because it absorbs fluid and its expansion could create neurologic complications. But in a laminectomy, the space is not confined.

22. Dr. McCormack opined that respondent's diagnosis of a malpositioned pedicle screw and his corrective surgery were not improperly delayed. A CT image showing the screw was incorrectly placed was obtained over the weekend; respondent operated on Tuesday. There was no emergency. It is generally better to wait for the best surgical support team for spine surgery, rather than a weekend crew that may lack experience. Dr. McCormack testified that he himself has more than once malpositioned a pedicle screw, and that it typically takes a couple of days to discover. Patients have incisional pain and are on narcotics; it usually takes three to four days for resulting leg pain to declare itself. In some cases, Dr. McCormack detects the malplacement intraoperatively, sometimes he does not discover it until months later, on a CT scan, where the patient is not complaining of leg pain. On Patient J.C., respondent performed decompression fusion at L3/4 in 2011; respondent continued the fusion down to the sacrum, which is commonly done to lower the risk of adjacent segment disease below. Patients do better than with a floating fusion (i.e., no extension down to the sacrum). Most surgeons would elect to extend the fusion down to the sacrum, but it is not a deviation from the standard of care either to extend or to decline to extend the fusion. Dr. McCormack cited an article in Neurological Spine Opinion in support of his opinion; the article highlights that there is some controversy regarding extending the fusion, but does not say extending the fusion is wrong.

23. Dr. McCormack opined that respondent's medical records were inadequate, confusing, and uninformative about his rationale and about what occurred each day. Nevertheless, Dr. McCormack opined from his review of imaging, Patient J.C.'s symptoms and pathology, and other information, there was no deviation from the standard of care in respondent's placement of the pedicle screw, his use of DuraSeal, and his timing of the pedicle screw revision surgery.

24. Respondent testified that he could not reasonably ascertain from intraoperative images that the screw was misplaced. He used imaging and an electric probe to ascertain whether the screw was breaching any bone or impinging on nerves. All of the techniques simply failed to give him the information needed to show that the screw had slightly breached the bone. Respondent's preoperative diagnosis was lumbar degeneration, an acceptable basis for performing a fusion, though the area is controversial. Severe disc degeneration at those levels also justifies laminectomy. There is no guideline, standard, or criterion addressing the question; it is up to the judgment of the surgeon. An L3-4 laminectomy is done when there is stenosis, a narrowing of the lumbar spine pressuring nerves in the spinal cord. The laminectomy, or decompression, gives the nerves more space. Respondent performed an L3-4 transforaminal interbody fusion with minimally invasive techniques. He placed a cage in the disc space to provide stability and realign the disc space height and angle to a normal position. He testified that one does not want to act too quickly to correct a misplaced pedicle screw. Even if he had known about the screw over the weekend from the CT scan, instead of on Monday when he saw the scan, he would probably

have watched and waited, he testified. It was not damaging a nerve, and there was no excruciating pain, weakness, or numbness, so waiting was the most prudent thing to do.

25. Respondent testified that he used DuraSeal off-label but not in a highly unusual manner. He used it to cement the fusion material in place, as scaffolding for bone growth. He testified that some papers report good results using glues of this sort in this manner, and because he did not use it in a tight space, near nerves, expansion of the product would be harmless.

26. Complainant established by clear and convincing evidence that, though respondent documented clear indication for the January 11, 2011 laminectomy to provide decompression, and even for fusion at the L4-5 level, respondent failed to document any clear indication for fusion at the L3-4 level and at the L5-S1 level. There were no findings of radiculopathy there and nothing in the records suggests the patient had L5-S1 discogenic pain. Complainant established by clear and convincing evidence that respondent's off-label use of DuraSeal as scaffolding for fusion carried unwarranted risks not justified by the literature. Complainant did not establish by clear and convincing evidence that respondent unjustifiably delayed revision surgery to correct the malpositioned screw.

Patient R.S. and Expert Testimony

27. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence, dishonest acts, and repeated negligent acts, created false medical records, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient R.S. in that he "(a) performed a wrong level surgery; (b) performed a spinal fusion without acceptable indication; (c) falsely documented and misrepresented an iatrogenic surgical error." (Ex. 1, First Amended Accusation, ¶ 45; see also ¶¶ 103, 110, 124, 127, and 129.)

28. Dr. Tantuwaya testified that respondent performed surgery at the wrong vertebral levels, installing a Coflex stabilization device that connected the spinous process of L3 to that of L5, instead of connecting L4 to L5, as intended. Respondent incorporated a level that was not implicated and increased the risk of adjacent segment disease at L2-3. Dr. Tantuwaya testified he is unaware of literature finding that extending a fixation device prevents adjacent level disease because it avoids "floating fusion syndrome." Respondent's error was reflected in intraoperative x-ray images demonstrating the device at the L3-5 level, postoperative x-ray and CT scan images showing the same, and radiologist reports of October 3 and 28 finding the device was at the L3-L5 levels. There was no acknowledgement in respondent's notes that he had performed surgery at the wrong level. Respondent conceded he did not realize the device was in the wrong level until after the surgery. Dr. Tantuwaya testified that reading the images is the responsibility of the spinal surgeon, not the radiologist and that, though four successive x-rays showed the device at the wrong level, respondent never realized it. Respondent's operative report shows an L4-5 decompressive laminectomy, interbody fusion and posterior Coflex interspinous stabilization.

29. Dr. Tantuwaya testified that there was insufficient indication for a fusion. Respondent told him he thought fusion was necessary because he was concerned about creating instability by a wide decompression. That would have been sufficient justification if it were documented, but there was no documentation of that when respondent performed the procedure and decided not to do a wide laminectomy. In the absence of documentation, there is no way to ascertain respondent's rationale. When doing a fusion, it is an extreme deviation from the standard of care if the reason for the surgeon's actions is not documented. And failure to document that he performed wrong level surgery and that he told the patient what happened is an extreme departure where complications are caused by iatrogenic surgical error, i.e., an error of the surgeon. When respondent was interviewed as part of the Board's investigation, he said he thought he fused L4-5, and conceded he misread the original x-ray and perpetuated that error on all four subsequent films. Where the surgeon has made an error, the surgeon must be honest, document the error, and discuss it with the patient. Dr. Tantuwaya saw no documentation of a discussion with the patient, or of respondent acknowledging he had made the error. Instead, respondent said he performed an additional operation due to a fracture of the L5 lamina. Dr. Tantuwaya saw no evidence of any such fracture. Rather, in the subsequent surgery, respondent put the device in the correct position. The corrective surgery was effective at alleviating the patient's symptoms. Dr. Tantuwaya opined that respondent's failure to document the wrong level surgery, and the misrepresentation of the reason for sending the patient back to surgery, strongly suggest an attempt to hide the complication. There was a very clear reason to go back and do surgery—the clamp was in the wrong place. The consent form that respondent had the patient sign should have said the surgery was for "repositioning of the clamp." Instead it said "possible repositioning," obfuscating the fact that respondent had made a mistake.

30. Dr. Tantuwaya also opined that respondent's documentation deficiencies, taken altogether, are not sufficient to warrant license revocation. This suggests that he believes respondent was not being deliberately dishonest about the reason for further surgery.

31. Dr. Bray testified that a surgeon may never discover he or she placed a spinal clamp at the wrong level if the patient does well. If the wrong placement is discovered, however, it should be repositioned. Dr. Bray opined that misplacement such as occurred in this case is not uncommon and is not a deviation from the standard of care.

32. Dr. McCormack testified that the decompression was at the correct level and the Coflex device was inserted at the correct level. The device is placed between two lamina, two adjacent vertebrae. If the surgeon must remove too much lamina in order to fit the device, there may not be enough material to attach the device to. Here, there was not enough L4 bone remaining, so the first bone available to which to attach the device was the L3. What remained in L4 was loose; it was not a fracture. This was not wrong level surgery; because of the amount of bone removed, the implant could not be placed just at L4-5, it had to be extended up to the L3 level. It provided fixation at the correct level, L4-5; respondent was adapting to the anatomy at the time.

33. Dr. McCormack testified that spondylolisthesis was an appropriate indication for fusion. There was glacial instability; most surgeons would do a fusion, though a laminectomy without fusion would also be within the standard of care.

34. Dr. McCormack testified that respondent's documentation was very poor and his operative report was confusing and below the standard of care, in his experience. Nothing in respondent's notes, however, appeared to be intentionally false. He did not document that he explained to the patient that he put a device in, the lamina was loose, and he had to extend the device to L3. The records do not contain enough information. When someone has a revision surgery, the doctor's thinking process should be reflected in the notes. They were not.

35. Respondent testified that Patient R.S. presented with back and leg pain. Conservative treatment had been ineffective. An MRI showed spondylolisthesis at L4-5, i.e., a slippage forward or backward of upper vertebra over lower vertebra, moving horizontally out of alignment. This is an indication of instability, which would cause back pain. And it caused nerve compression with resultant leg pain. Respondent recommended a laminectomy and fusion at L4-5. The procedure had no apparent intraoperative complications, but it was an extensive laminectomy in which respondent removed a great deal of bone from both levels, due to the severe degree of nerve compression. He tried to preserve the spinous process, the bump of bone in the middle of the lamina to which the clamp attaches. He placed the clamp over what he thought was L4-5, but the clamp actually spanned from L3 to L5. It was not harmful; the laminectomy was at the correct level, there was decompression, and the clamp was stable, functioning as intended. Respondent testified he only realized the clamp was at L3 after his observations during the second surgery and again reviewing the images. When the patient started having more pain after the first surgery, respondent became concerned and ordered a CT scan. He testified that he thought, based on the CT scan, there might be a fracture of one of the lamina due to the clamp, so he recommended another operation. In the second surgery, respondent testified, he was able to remove the excess fractured bone as well as the clamp, and he stabilized the area with pedicle screws.

36. Respondent testified that it took him awhile to figure out that, because the L4 spinous process was a mere nub and the spinous processes of L3 and L5 were right next to each other, as if they were L3 and L4, he had placed the clamp as if they were L3 and L4. He testified that he feels badly about making this mistake and causing the patient to have another surgery. This testimony implies that the reason for the second surgery was to correct the mistake, not because of a fracture. In fact, he testified that a fracture of a lamina during the installation of a Coflex clamp would be very obvious to the surgeon.

37. Respondent testified that he discussed the clamp surgery with patient before the operation and the second surgery, and advised the patient that the clamp went to the L3 level, but it is not clear from his records that they discussed it in detail. He testified it would certainly have been part of the discussion, though not a major aspect; the patient's lamina was fractured, he needed additional decompression and stabilization and, due to an anomaly in his anatomy, L3 and L5 were right next to each other. Respondent thought there might be

a fracture, and the pattern of the patient's pain and spine mobility reinforced his suspicion of a fracture, so he recommended revision. There was a fracture, in fact, at L5. After that surgery, respondent told the patient of the fracture. This explanation of the reason respondent thinks he may have provided the patient for the second surgery is not convincing in light of all of respondent's testimony. In the second surgery, respondent removed the lamina and the clamp and stabilized the level. Some months later, looking back at the films, he realized why the clamp looked like it was at the wrong level; it was not at L3-4 or L4-5, it was at L3 to L5. It spans the correct level, but also includes the level above. The laminectomy was at the correct level, the intrabody fusion was at correct level, and the clamp spanned the correct level and an additional level above. Respondent asserted that it was not gross negligence.

38. Respondent testified that the patient's pain was related to the fracture, which caused bone to be driven into the nerves in the spinal canal; the fracture occurred because of force on the lamina from clamping the spinous process. Whether it spanned from L3 to L5, or L4 to L5, the L5 lamina would have fractured anyway. According to respondent, this was the important thing, not the anatomic anomaly; the fracture and nerve impact had to be corrected. Respondent told the patient there "may be" a fracture and recommended going back to surgery. When respondent reopened, he saw that the L5 lamina had fractured, and he cleaned it out and stabilized it by installing screws and rods. Respondent testified he told the patient this after surgery. Respondent testified he had not discovered the clamp was at L3 to L5 before the second surgery. If he had known, and the patient had no symptoms, he would not have operated to correct the clamp. He operated again because the patient needed some correction; there was a mechanical problem and nerve compression, and respondent believed it was due to a fracture.

39. Respondent testified it is his practice to look at every film he has ordered, as he did in this case, and when possible to look at the radiology report, which sometimes is not available. He does not remember whether he told the patient that some image studies showed work at L3-4 and L3-5, though respondent thought he had fused L4-5. He claimed that before the second surgery, he and the patient were focusing on why the patient was in so much pain, and respondent did not think the location of the clamp had anything to do with the pain. And, in fact, it did not. The clamp was far from any nerves, and Patient R.S. was having nerve pain and mechanical pain, indicating a fracture. So whether clamp was at L3-5 or L4-5 would not have been relevant. He does not remember whether he told the patient about the location of the clamp after the second surgery was completed. It is not documented in respondent's medical records, which were created using older software and are difficult to read.

40. Patient R.S. testified that he first saw respondent on August 29, 2012. He had severe bilateral leg pain and lower back pain. He brought an MRI, which he and respondent reviewed. Respondent recommended surgery using a Coflex clamp and a spacer between L4 and L5, with no rods or screws. The surgery was on October 12, 2012, at Hoag Hospital. Before he left the hospital, R.S. testified, his left leg hurt, very badly, more than it had hurt before surgery. At an October 10 follow-up appointment, R.S. described his severe left leg pain; respondent said it was post-surgery pain and would take time to resolve. R.S. was

hospitalized on October 28 with fever and severe left leg pain; he remained in the hospital until November 8, 2012. Eventually, another physician who saw R.S. for his leg pain examined the images and told the patient that the clamp was in the L3-4 space and an artificial disc was between L4 and L5. Respondent had told the patient that the disc between L4 and L5 was not supporting vertebrae and had to be replaced with an artificial disc. After another operation on November 1, the left leg pain was dramatically reduced and other symptoms improved. Patient R.S. felt respondent had been dishonest because respondent did not disclose that the clamp was not placed where it was supposed to be placed and did not disclose anything about a broken lamina. Then R.S. testified, however, that he was not sure whether respondent told him before the second surgery that his gait seemed to indicate a possible fracture. After the second surgery, respondent visited Patient R.S. in the hospital and told the patient that he had had to remove the clamp and use rods and screws because there was a broken lamina. In February 2013, Patient R.S. told respondent that his back was better.

41. Complainant established that respondent performed wrong-level surgery, not realizing that the clamp connected L3 and L5. Complainant did not clearly establish the absence of an appropriate indication for fusion surgery, that is, that respondent's rationale that he expected to do such an extensive decompression that instability was likely to result could not justify fusion. Complainant established that respondent's records were so poor as not to reflect his otherwise acceptable rationale for the surgery. Complainant did not establish by clear and convincing evidence that respondent deliberately misrepresented an iatrogenic error in his records and communications with the patient.

Patient R.H. and Expert Testimony

42. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence and repeated negligent acts, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient R.H. in that he "(a) operated on the wrong level and misread an intraoperative x-ray prior to closing and concluding the case; and (b) performed a surgical procedure without clear and/or documented indications." (Ex. 1, First Amended Accusation, ¶ 55; see also ¶¶ 112, 127, and 129.)

43. Dr. Tantuwaya testified that respondent identified retractors at the L3-4 level, and went one level down to what he thought was L4-5. An intraoperative x-ray demonstrated wrong level surgery. But the patient was closed and taken out of surgery. Respondent then discovered the error, notified the patient and family, took the patient back to surgery, repositioned the clamp, and performed decompression at correct level. There was no delay in taking the x-ray; it took 30 minutes for the radiologist to write it up, but the surgeon should read it in real time, as soon as it's printed, and should not close the patient unless image shows where the hardware is. In this case, fusion was performed by clamp, not screw. A clamp fixes adjacent spinous processes together; screws are anchored in the vertebral bodies themselves. To correct a misplaced clamp, the surgeon must take it out and put it in at the correct level. There is no substantial risk to this correction procedure, but there is substantial risk to not correcting it.

44. Spinal fusion without acceptable indications is extreme departure from the standard of care. A characteristic of instability, which is an indication for fusion, is intractable back pain. Here, the patient denied back pain and there was no documented instability, because respondent obtained no flexion and extension x-rays. There were no indications for fusing the patient. According to Dr. Tantuwaya, an MRI showed that the patient had only minimal spondylolisthesis. Respondent's notes show that the patient denied any low back pain.

45. Spinal fusion can be achieved by graft only, by graft and instrumentation, or by instrumentation only. Performing fusion without instability or some evidence that the disc being fused is a pain generator is an extreme departure from the standard of care. Respondent documented that he believed stenosis was the source of the patient's pain, but that does not justify fusion. If the disc were the source of the pain, however, that would justify fusion. There has to be an indication for doing fusion in absence of instability. If, e.g., decompression by removing a significant portion of the facet joints will make the patient unstable, that would be an indication for doing fusion. Or if, for example, the surgeon is trying to perform an indirect decompression of the neuroforamen, where initial decompression has failed, and the patient has foraminal stenosis, then a fusion is an indirect way to decompress. And positive discography could provide at least some evidence that the disc is the pain generator, even though discography returns false positives. The pain generator in this case was stenosis, i.e., the compression of the nerve. The surgical treatment for that is decompression, not fusion. There was no basis for fusion or for placing a clamp instead of doing a bone graft. The decision to perform a fusion was an extreme departure from the standard of care.

46. Respondent's misreading of the x-ray regarding the position of the clamp is an extreme departure from the standard of care. Respondent agreed, in his Board investigation interview, that it was his responsibility to read the film in a manner that allowed him to accurately determine where the clamp was located, and that he misread the x-ray.

47. Dr. Tantuwaya does not believe respondent honestly told the patient he made a mistake. His consent form says the follow-up surgery will be for "possible repositioning of interlaminar clamp." If he had told the patient of his mistake, he would not have written "possible" repositioning. While this inference may be true, it is not so strong as to establish clear and convincing evidence of dishonesty.

48. Dr. McCormack testified that instability is not a necessary prerequisite for spinal fusion. Mechanical instability of two vertebrae is the best indication, but glacial instability (slow collapse, like spinal stenosis), or grade 1 spondylolisthesis, or discogenic low back pain, could be enough to show fusion is warranted. For spinal stenosis in older patients where the disc is collapsed, the standard surgery is a laminectomy (i.e., decompression). Many surgeons will perform, though, a junctive fusion. It stiffens the spine, and patients seem to do better with a stiffer back; this is supported in the literature. Dr. McCormack did not establish, however, that a junctive fusion was within the standard of care in this case.

49. This patient was 76 years old, with stenosis at L4-5. Dr. Tantuwaya says respondent performed a wrong level surgery. It was, in fact, a wrong level clamp. The decompression was at the correct level, L4-5, but the Coflex device was put in at the wrong level, the L3-4 level, rather than the L4-5 level. The patient was brought back to surgery and the clamp was placed at the correct level. The clamp is placed between the two lamina; if bone is removed, the device can have a variable relationship with the disc and can encompass two levels. This device has only been used for the past five years, it is new technology. Respondent's error was a simple, not an extreme, departure, especially because it was addressed immediately.

50. Dr. McCormack saw no evidence that respondent ignored x-rays. He got two x-rays, he had some questions in the recovery room, realized the clamp was in the wrong level, and addressed it. In 2013, using older fluoroscopy, it could be difficult to tell whether the device was in the wrong place. In fact, respondent instituted a change to digital imaging at Hoag Hospital to use more advanced technology. He also effected a change in policy there by advocating that spine surgery not close until the surgeon confirms the correct placement of a device.

51. Decompression with insertion of a clamp, but no bone, is not a spinal fusion. Implantation of bone is usually a necessary component of fusion, though a surgeon can fuse certain joints without a bone implant. In this case, there was no fusion performed. The Coflex device was designed to offload the facets and stiffen a level. In respondent's office notes, there was information sufficient to justify this surgery: severe spinal stenosis at L4-5 and minimal anterolisthesis without overt spinal instability.

52. Respondent testified that he used the Coflex device, a kind of clamp, as an adjunct to laminectomy, in lieu of more invasive devices and techniques such as screws and fusion. The device adds stability, where the laminectomy creates a potential for some instability. If, in the course of a laminectomy, there is a high likelihood of creating instability, that is an indication for fusion. Fusion prevents the need for a second surgery due to instability resulting from the first surgery. This patient was 76 years old and had lumbar stenosis with pain in his right leg; an MRI showed severe L4-5 spinal stenosis. The diagnosis was lumbar radiculopathy. Respondent recommended a laminectomy at L4-5 with a Coflex clamp, and he still stands by this recommendation. This is the ideal patient and indication for the Coflex clamp. The clamp cannot replace pedicle screws and rods because it is not as strong, but in cases where adding stability to a laminectomy, the Coflex device is appropriate.

53. The laminectomy was at the correct level, and achieved a successful decompression. But the clamp was at the wrong level. There was no fluoroscopy in the operating room at Hoag, so respondent had to call in an x-ray technician to take a plain x-ray; it was a plate, not digital, and had to be developed and scanned into system, so it was 10 to 15 minutes before respondent could review it. In this case, several x-rays had to be taken because of suboptimal x-ray technique; the x-rays were poor. In the final image, it looked to respondent like the clamp was at the correct level, and he proceeded to close. He then went

to the radiology department, looked at the viewer there, and saw the clamp was not at the correct level. He told the patient and recommended going back into surgery to replace the clamp; this is reflected in his progress note and a consent form. Misplacing a clamp requires immediate correction, unlike a pedicle screw.

54. Respondent worked with Hoag Hospital to improve the system, instituting digital fluoroscopy in every spine case. New policy also required that an x-ray be looked at by a radiologist to confirm the instrument was in right location before closing.

55. Respondent acknowledged it was his responsibility as the surgeon to make sure the clamp was in the right place, and he accepts responsibility for the error. After so many poor-quality x-rays, he could have called and asked a radiologist to look at the x-rays before he closed, but he testified he had no reason to suspect the clamp was not in the right place.

56. Complainant established that respondent departed from the standard of care when he performed a wrong level surgery, in effect, by inserting a stabilization device at the wrong level. Complainant did not establish that respondent departed from the standard of care when he misread an intraoperative x-ray. Complainant established that respondent performed the fusion without clear, documented indications.

Patient M.M. and Expert Testimony

57. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence, dishonest acts, and repeated negligent acts, created false medical records, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient M.M. in that he "(a) failed to recognize intraoperative complications and/or expeditiously recommend appropriate treatment; and (b) used false, negligent and/or misleading documentation of surgical errors." (Ex. 1, First Amended Accusation, ¶ 73; see also ¶¶ 105, 114, 126, 127, and 129.)

58. Dr. Tantuwaya testified that, during his April 5, 2012, operation on Patient M.M., respondent placed an interbody cage; he inadvertently pushed the cage through the disc and beyond the front border of the bones, causing a tear in blood vessels and resultant bleeding. This was an iatrogenic, surgical complication, though it was not in itself a departure from the standard of care. But in all of his documentation, including office visit notes, he does not note that he caused the bleeding, and he refers to it as a medical complication not a surgical complication. A medical complication refers to something resulting from the patient's medical condition. This was a surgical complication, due to respondent puncturing the blood vessels during the surgery. It reflects an attempt to obscure the complication. On cross-examination, however, Dr. Tantuwaya acknowledged that he was not aware of certain definitions in the literature of "medical error," and, more crucially, that respondent's operative report, both in the hospital's records and the patient's chart, stated that it was apparent upon insertion that the cage graft had protruded, which did not appear to Dr. Tantuwaya to be an attempt to avoid saying there was a surgical error. This testimony negates Dr. Tantuwaya's opinion that respondent attempted to obscure this complication.

59. Respondent could not complete the surgery because of the bleeding, so he performed a second surgery on June 5, 2012, to do the fusion. He inserted a malpositioned screw, which was not properly anchored, as reflected in images. But respondent's notes repeatedly and incorrectly say the images are "stable." Respondent then took the patient back for a third surgery to correct the malpositioned screw, but wrote in his records that the reason for the surgery was to do a "more thorough fusion." His notes say he told the patient a more thorough fusion was needed because of the minimally invasive nature of the first surgery; they do not reflect that he told the patient about the malpositioned screw.

60. Dr. Tantuwaya testified that respondent failed to recognize intraoperative complications, i.e., the malpositioning of screws, and expeditiously recommend appropriate treatment. Respondent looked at a lateral image during surgery, but failed to take and examine an AP image; this itself was an extreme departure from the standard of care. The criticism is not that respondent misplaced a pedicle screw, but that he did not recognize from the films that he incorrectly placed the pedicle screw, an extreme departure from the standard of care.

61. Falsely documenting the postoperative films respondent reviewed was also an extreme departure. There were four or five opportunities for respondent to note the intraoperative error he had made when imaging studies were done after the surgery, but he did not do so. Instead, there is little documentation of his assessment of the first surgery and of the second surgery he performed on June 5, 2012. Spinal surgeons should be capable of reading spine films themselves; respondent either read the postoperative films improperly, or he did not read them, or he was dishonest about what they revealed. The left L4 screw is clearly malpositioned, as demonstrated by four postoperative studies, some of which respondent himself ordered and should have looked at. He noted they show "x-ray stable." This was not true. The patient had increasing pain, and her spine was not fusing and was unstable, with dire neurological consequences. Two x-rays on July 23, 2012, and an x-ray on September 5, 2012 show that anterolisthesis, a slippage of one bone on top of the other, was increasing, and this was confirmed by a radiologist report. Respondent's notes in which he says the x-rays are stable do not indicate which x-ray he is referring to, but there were images showing a malpositioned screw. The pedicle screw is supposed to travel through the pedicle, a bridge of bone. On patient's left, the screw is correctly positioned. On the patient's right, a second screw misses the pedicle entirely.

62. Respondent saved a lateral image in his files; it is possible that an AP image exists in Hoag's records, since respondent stated in the subject interview that he took one, but Dr. Tantuwaya did not find it. Dr. Tantuwaya did not conclude that respondent was responsible for maintaining the image in his records. In any case, if an AP x-ray was taken, it would have shown the malpositioned screw. The surgeon would either move it or explain why he elected to leave it in an aberrant position; for instance, he may have thought the risk of repositioning it was too high. Instead, respondent wrote, and testified, that the x-rays demonstrated that the screws, his construct, were stable. "Stable" means one of 2 things: either everything looks right, or nothing has changed since prior film. If a misplaced screw does not move for months, it can legitimately be called stable, if the surgeon compares it to a

prior study and references the prior study, which respondent did not do. It is true that the radiologist's postoperative image reports twice said the screw construct was stable. But Dr. Tantuwaya believes that a spine surgeon's reliance on a radiologist report, rather than reading the images after receiving the radiologist's report and documenting his own impressions, is a departure from the standard of care. Respondent did not prepare a report saying what he believed the x-rays showed. If he had documented that an L4 pedicle screw was in malalignment, and his reason for leaving it, and then subsequently wrote it was stable, that would not be misleading.

63. A December 26, 2012, imaging report showed the apparatus coming loose; respondent made a subsequent entry recommending revision surgery. The image showed an area of lucency, indicating a misplaced pedicle screw and loosening hardware. But the lucency was present on the prior films also, and respondent should have detected it, despite what the radiologist reported. And respondent never documented that the screw was in the wrong position. The misplaced pedicle screw was causing the screw and rod construct to begin moving shortly after the surgery.

64. Respondent used electric conductivity during surgery to ascertain whether the screw breached the wall of the pedicle or was in proximity to a nerve; that tool does not reveal where the screw is, and using it does not prevent misplacement of pedicle screws.

65. Imaging after the June 5, 2012, surgery showed a misplaced pedicle screw. Respondent's notes are poor and difficult to interpret, and they do not provide enough information to make a determination regarding additional surgery. Respondent wrote in a November 7, 2012, note that the patient did not wish to undergo more surgery. He did not write that he told the patient her screws were improperly placed and should be fixed, though this is not required by the standard of care. The standard of care does require that the rationale for performing surgery be documented; it was not adequately documented in this case. Writing that the patient required a more thorough fusion does not indicate that the hardware was loose and the patient unstable. Respondent apparently did not think it prudent to go back in until it was clear the patient was not fusing, but there was ample evidence before September 2012 that he should have previously taken her back to surgery.

66. Dr. Bray testified that it is not an extreme departure for a spine surgeon not to read the x-rays if they are read and reported on by a qualified radiologist. Radiologists have the higher level of expertise for that purpose. Dr. Bray conceded that it is his practice to review all x-rays that he has access to digitally, but he testified that is not the standard of care. Respondent, however, acknowledged in the subject interview that he, too, reads all films, regardless of whether he has a radiologist's report.

67. Dr. Bray testified that the literature shows that up to 30 percent of pedicle screws are misplaced, due to imperfect imaging and a resulting high misinterpretation rate; this is acknowledged as one of the risks of surgery. Dr. Bray himself has installed hundreds of pedicle screws and has misplaced some screws. If he learns of the misplacement intraoperatively, he repositions the screw, but most screw misplacements are found by

postoperative CT scan, and most do not pose a risk of harm. The literature states that, if there is no risk of neurological or vascular harm, the classic case for revision of the screw, the surgeon should not automatically do a revision surgery, but should monitor how the patient does; only a small percentage require repositioning. Also, only 50 to 90 percent of fusion surgeries are successful, so, breach or not, there is a significant risk of failure. If fusion succeeds, and it usually takes up to four months to ascertain success, there is no need to remove the screw unless it bothers the patient. Even where postoperative images show lucency, indicating that the screw came loose, it is still very common to wait and see whether the bone becomes progressively more solid. It is not uncommon that the screw becomes loose but the fusion becomes successful.

68. Dr. Bray opined that, if a surgeon tells a patient that the x-ray is stable, it means there has been no significant change from the last x-ray. A surgeon who discovers he or she has made an iatrogenic error must document it. The term "medical complication" is all-encompassing and includes surgical complications and other mishaps, whether physician-caused or not.

69. Dr. McCormack testified that the opinion of a board-certified radiologist carries more persuasive weight about the meaning of an image than that of a surgeon. It is the standard of care for surgeons to rely on the radiologist's report.

70. Dr. McCormack agreed with Dr. Tantuwaya that respondent failed to recognize the misplacement of pedicle screws during the June 5 operation. But, he testified, malpositioning happens about ten percent of the time, and it is not below the standard of care. It can happen despite using all techniques, including intraoperative CT and K-wires. Dr. McCormack misplaces a pedicle screw and has to bring the patient back for surgery every two or three years. More frequently, there is no need to revise the surgery because the screws do not necessarily cause a problem. Respondent used fluoroscopy, nerve monitoring, and a Jamshidi needle (a small needle that is used in minimally invasive spine surgery). Minimally invasive surgery probably increases the risk of error due to limited direct visualization. If lateral, the screw is not likely to impinge on nerve. If medial or inferior, it's inside area where nerves reside, and more likely to cause problems. If a screw is laterally misplaced, so it is not likely to impinge on a nerve, a surgeon should not immediately operate again, but should monitor the patient for fusion, obtain serial x-rays, and see whether the patient experiences increased pain. If the fusion is failing, x-rays will show lucency around the screws and progressive listhesis. If lucency appears in a single x-ray, that is not enough to warrant revision. For the first three to six months after surgery, an x-ray is a blunt instrument; clarity comes with time. A CT scan would give better information. If an x-ray shows increased listhesis, it is appropriate to order a CT scan. In this case, respondent learned after the surgery that the screws were not placed properly.

71. The operative report shows the surgery was done appropriately. Respondent operated on June 5, 2012. A July 23, 2012 x-ray shows the left L5 screw was laterally misplaced. Nothing here warranted revision surgery; it should cause enough concern to warrant ordering more x-rays and monitoring the patient's condition. The screw would not

stabilize the level for fusion, but this report does not indicate whether the fusion is failing, and one cannot conclude from this report that revision surgery is necessary. The October 31, 2012 CT scan report causes significant concern that the fusion was possibly failing. An x-ray report from two days earlier said the fusion was stable; the intrabody graft had not shifted, and there was still a possibility of fusion, though the patient was now experiencing back pain. Respondent, therefore, asked for a CT scan, a reasonable approach. And after reviewing the CT scan, respondent discussed with the patient the option of open revision surgery with a complete laminectomy, also reasonable at the time, but the patient did not want further surgery. Respondent scheduled a follow-up visit, which was a good plan.

72. A December 26, 2012 CT scan, when compared with the October 31 CT scan, clearly indicated that the fusion was failing. At this point, Dr. McCormack would recommend revision surgery; he might have recommended it when seeing the October 31 CT scan, but not doing so was not a deviation from the standard of care.

73. The documentation on this patient was poor. For example, x-ray reports mention a malpositioned screw, but respondent did not address that in his note or document that he discussed it with the patient. Dr. McCormack opined that the use of the term "medical" complication does not appear deceptive; it includes surgical complications.

74. Respondent testified that Patient M.M., a 54-year-old woman, presented with worsening back pain and leg numbness who had tried chiropractic and medication. An MRI showed spondylolisthesis, or instability, at L4-5, disc protrusion, and stenosis. Respondent recommended an L4-5 decompression and fusion. Respondent performed a laminectomy, but then, in the process of placing an interbody cage into the disc space, the cage penetrated the anterior margin of the disc, the annulus, so the front half of the cage was protruding. The injury was repaired with no permanent ill effects. After the patient recovered, respondent operated again, to place the screws, using minimally invasive techniques, and intraoperative fluoroscopy. After the surgery, she continued to have back pain. After serial x-rays of the lumbar spine, it became apparent that she was not fusing at the level of surgery. There was no solid bone, and there was lucency around screws, indicating loosening because lack of fusion. Even with a loose or misplaced screw, there can be enough stability that the patient does fuse and does not require revision surgery to fix the screw, so it is appropriate to watch the patient over time.

75. Respondent testified that he used the term "medical complications" to detail what had happened in the first surgery. He did not intend to hide the surgical complication, which is quite apparent from the medical records. Respondent's April 3, 2012, operative report reflected that the interbody cage placement resulted in a vein injury requiring an emergency laparotomy. This weakens complainant's allegation that respondent's use of the term "medical complication" was intended to conceal what had happened. Respondent's use of the term "stable" in describing imaging was intended to indicate no change from the prior imaging. Respondent acknowledges that he did not mention in his notes that there was a loose screw, and that in his assessment and plan he should have been more thorough about describing his thought process.

76. The October 29, 2012 x-ray report showed that the spine was stable and there was no reason to believe the screw was interfering with the fusion. Eight days later, on the patient's next visit, which was after the CT scan, respondent spoke with the patient about open revision surgery. The June 5, 2012, operative report reflects the placement of the screws and rods at L4-5. The final x-ray looked satisfactory. Sensory and motor evoked potentials were normal, and stimulation mapping confirmed there were no nerves nearby and did not indicate the pedicle screw was been placed incorrectly.

77. Respondent acknowledged that the electronic medical records software he was using at the relevant times resulted in notes that were cumbersome and difficult to interpret. He uses better software now, and personally manually makes all entries.

78. In the First Amended Accusation as further amended at hearing, complainant alleges respondent failed to recognize an intraoperative complication, i.e., the malpositioning of the pedicle screw. The weight of the evidence does not support that there was any departure from the standard of care during the surgery. Respondent utilized numerous tools to assess whether the screw had been correctly placed. The misplacement of the screw itself was not alleged to be a departure, and the evidence does not demonstrate that respondent should have been able to detect the displacement intraoperatively. Post-surgery, over time and with the aid of multiple images and imaging studies, respondent recognized that the screw was not positioned correctly and, more importantly, that fusion was not occurring, and recommended revision surgery. Regarding the allegation that there were intraoperative complications that, later, respondent delayed addressing, the evidence does not sufficiently support a conclusion that respondent failed to expeditiously recommend appropriate treatment. In December, based on a CT scan report, respondent recognized a fusion failure and recommended surgery; the patient refused. He continued to recommend surgery on the follow-up visit the next month.

79. The evidence as a whole does not clearly support the allegation that respondent falsely or misleadingly documented the complications. While, standing alone, his characterization of the complication as "medical" might tend to be misleading, though even that is not clear, the concurrent operative report clearly describing the complication removes any doubt about what actually occurred. Though complainant did not establish false or misleading documentation, the evidence, including respondent's testimony at hearing, supports a conclusion that respondent's recordkeeping with respect to this patient did not meet the standard of care.

Patient G.V. and Expert Testimony

80. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence and repeated negligent acts, created false medical records, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient G.V. in that he "performed the February 19, 2013, surgery without clear indications and/or documenting those indications." (Ex. 1, First Amended Accusation, ¶ 78; see also ¶¶ 116, 127, and 129.)

81. Respondent saw Patient G.V. on February 4, 2013. Respondent had performed a laminectomy on Patient G.V. in 2008. Now the patient had low back pain of 3 to 7 on a scale of 10. He had left hip and thigh pain, 1 to 7 on a scale of 10. He had left leg weakness and foot drag. He had tried conservative treatment. He experienced mild left iliopsoas muscle weakness, the muscle that helps flex the hip. According to Dr. Tantuwaya, this was the only positive finding in respondent's note. That muscle is innervated by the L1-2 nerve root, maybe the L3. Dr. Tantuwaya opined that the patient's symptoms did not themselves justify surgery, there had to be concordance with signs and diagnostic information. Respondent noted his interpretation of December 29, 2012 MRI images. There were degenerative changes, especially at L3-4, and moderate to severe bilateral foraminal stenosis. Dr. Tantuwaya found that the patient's symptoms, iliopsoas muscle weakness, and the radiographic studies were not concordant and so did not substantiate the surgery respondent performed. Respondent performed an L2 to S1 decompression fusion; weakness of the iliopsoas muscle is L1-2, and there was no dysfunction of lower nerve roots, e.g., S1. So there was no indication for decompression; there were no exam findings that the patient's nerves were compressed. And respondent performed a fusion across five levels: L2, 3, 4, 5 and S1. The patient did not fulfill any of the criteria for performing fusion. There was no justification for L4-5 or for L5-S1, and no strong justification for L3-4, just stenosis on the MRI.

82. Respondent charted no exam findings or significant radiographic findings for L4-5 or L5-S1. At the L3-4 interspace, respondent documented stenosis, the most significant radiographic finding. But no exam findings strongly suggest involvement of that level. The patient's pain in the upper thigh and hip and the weakness could support decompression at the upper levels of L2-3 and L3-4, but not for other levels. Respondent did not note that his laminectomy will render the patient unstable, thereby justifying fusion. To do decompression fusion from L2 to S1 usually would take 5 to 8 hrs. Decompression only, for L2, 3, 4, would normally last about 2 hrs. Lengthier surgery poses additional risks. Because of those risks, this was an extreme departure from the standard of care.

83. Dr. McCormack testified that respondent did an indirect decompression. Four levels is a lot of surgery, he testified, but it is well within the standard of care.

84. Respondent testified that the patient had back and leg pain and weakness, and had been taking prescription narcotics for some years. Respondent concluded the symptoms could reveal degenerative disc or facet disease, and the leg pain could indicate stenosis. The pain was progressive, intractable, and disabling. Respondent discussed options for treatment, including surgical fusion. Respondent told Dr. Tantuwaya in the subject interview that he looked at all the films and read the radiologist's report, which was his practice, because the surgeon's interpretation of the films is the more important than the radiologist's. This contradicts the testimony of respondent's own expert witness. Diagnostic data revealed severe disc degenerative changes most severe at L3-4, and instability. The patient had bilateral foraminal stenosis, a narrowing of opening for nerves to exit the spine and go into the legs, so those nerves were being impinged. The patient had the feeling of dragging his left leg; respondent found a weakness of the hip. Extensive disease made respondent think

twice about recommending fusion. But the patient had been through the entire range of treatments and was getting worse, so surgery was warranted. Laminectomy alone would not have addressed his back pain; also, he had already had a laminectomy, so removing additional bone would have increased the risk of instability.

85. Complainant established in part that respondent performed the February 19, 2013, surgery without clear and documented indication, only insofar as the fusion extended to L4-5 and L5-S1.

Patient W.C. and Expert Testimony

86. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence and repeated negligent acts, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient W.C. in that he "performed the February 9, 2012, surgical procedure without clear and/or documented indication." (Ex. 1, First Amended Accusation, ¶ 88; see also ¶¶ 116, 127, and 129.)

87. Dr. Tantuwaya testified that, in a February 1, 2012 note, respondent wrote that Patient W.C. presented with low back pain that became worse with activity, and mild posterior thigh pain. This was very nonspecific and was not sufficient by itself to justify surgery. Respondent did not document any abnormal findings, any neurological deficits, or any objective signs of nerve dysfunction. An MRI revealed L5-S1 degenerative disc disease and L3-4 and L2-3 stenosis due to a congenitally narrow canal. Without signs or some other form of evidence confirming nerve dysfunction that correlates to that level, one cannot say this level is responsible for all of the patient's symptoms. And nothing points to the L5-S1 level, not even radiographic study. Respondent performed a minimally invasive transverse lumbar fusion at L4-5, attaching pedicle screws at L4 to S1. That means he fused three segments (L4, L5, S1) across two interspaces (L4-5, L5-S1.) He did not fuse or do decompression, he just placed screws. The instruments, in this case screws, do not fuse the level, they are an adjunct to fusion. Instrumenting across the L5 to S1 interspace was not indicated and is an extreme departure from the standard of care; it lengthened the procedure, increasing risk to the patient, and placing screws presents the risk of injuring a nerve root or blood vessel, entirely unnecessary here. The work at L4-5 was reasonably indicated.

88. Dr. McCormack testified that the patient had spinal stenosis at L4-5, warranting either a laminectomy or a laminectomy and fusion. Respondent extended the surgery down to S1 for other symptoms. Contrary to Dr. Tantuwaya' s testimony, good results can now be obtained with screws only, without a bone graft. The patient had a collapsed disc at L5-S1. One can achieve spontaneous fusion at S1 without a bone graft. And extending the surgery to S1 avoided a floating fusion and adjacent segment disease. The patient had later surgery, but not at the L5-S1 level, because it was no longer identified as a problem.

89. Respondent testified that Patient W.C. had a history of back pain and thigh pain, limiting his walking. The MRI scan showed significant disease at two levels: L5-S1

disc degeneration, and L4-5 severe stenosis. This indicated surgical intervention. Respondent recommended a two-level fusion, with an interbody cage replacing the disc at L4-5 to relieve foraminal stenosis and, at L5-S1, because there was so much degeneration that a cage would have been too complicated. The procedure was a posterior fusion involving pedicle screws and rod fixations. There was no problem and the surgery was uncomplicated with a good outcome.

90. Respondent acknowledged he kept poor records, and he could not be certain that a January 20, 2012, MRI of the lumbar spine identified at hearing was the one he reviewed before the surgery.

91. Complainant did not establish that respondent performed the February 9, 2012, surgical procedure without clear and documented indication.

Patient M.R. and Expert Testimony

92. Dr. Tantuwaya testified in support of complainant's allegations that respondent committed gross negligence and repeated negligent acts, failed to maintain adequate and accurate medical records, and engaged in unprofessional conduct in his treatment and care of Patient M.R. in that he "failed to obtain follow-up imaging to confirm adequate healing prior to terminating external immobilization in an elderly, osteopenic woman with a type 2 odontoid fracture" and "failed to identify any intra-operative contra-indications to odontoid screw placement." (Ex. 1, First Amended Accusation, ¶¶ 99, 100; see also ¶¶ 121, 127, and 129.)

93. Dr. Tantuwaya testified that respondent did not deviate from the standard of care in his preoperative evaluation for this surgery; there was no preoperative contraindication. But he committed an extreme departure from the standard of care by failing to identify intraoperative contraindication to an odontoid screw placement. When placing an odontoid screw that connects two pieces of broken bone, the surgeon must have lined up the two pieces. Here, Dr. Tantuwaya testified, the two fracture fragments were not lined up, based on intraoperative and postoperative radiographic studies. There was a report of the postoperative CT scan confirming that the screw did not traverse across the fracture and connect the bones.

94. A September 17, 2013 x-ray showed a lateral view of the cervical spine after the screw was placed. The bone is fractured and one piece of the bone, the odontoid, is separated. Dr. Tantuwaya testified that if the surgeon cannot confirm definitively that the broken piece of bone is lined up with the other piece, then placing the screw is an extreme departure. Directly behind and above the odontoid is the brain stem, so there is very little margin for error; if the brain stem is damaged, it could result in severe neurological deficits, coma, and death. This x-ray image does not clearly show the odontoid, the broken peg of bone off the C-2 body, lined up with the cervical bone itself; relying on this image, the surgeon must not place the screw. In fact, the screw missed the odontoid because the bones were never lined up or moved out of position before respondent placed the screw.

95. Michael L. Levy, M.D., testified that he wrote a textbook chapter on odontoid fractures and is very familiar with this patient, having testified on behalf of respondent in a civil lawsuit arising out of this surgery. In an elderly patient with an odontoid type 2 displaced fracture, such as Patient M.R., the patient's health is endangered. A surgeon might choose to immobilize the patient in a soft or hard collar or halo, but there is still high mortality. Or the surgeon might perform neurosurgical intervention, either anterior or posterior. It is not a standard of care choice; all options are within the standard of care. Surgical options have better results earlier in elderly patients, and the surgeon can insert an odontoid screw to connect the two portions of the odontoid that have been displaced. The screw stabilizes and reduces (closes the gap between the piece of fractured bone and the base, increasing the chance of fusion). If the surgeon waits too long, only posterior fusion surgery is possible, which is more dangerous for the elderly than anterior surgery. Posterior fusion takes longer, requires a larger incision, and requires a graft. The first step is always immobilization, usually with the use of a hard collar.

96. Two weeks after respondent had recommended surgery, Patient M.R. was admitted to the Hoag Hospital emergency room on September 16, 2013, with dizziness, nausea, and head pain. The pain was most likely a symptom indicating an unstable fracture. A CT scan showed a small amount of distraction that had increased the fragment's distance from base of fracture, more displacement, and no evidence of bony fusion, i.e., the situation was worsening. Respondent attended the patient in the emergency room. He reviewed the CT image and again discussed surgery with the patient. The patient requested an anterior approach with an odontoid screw. Respondent performed the anterior surgery the next day. Patient M.R. was an appropriate patient for this approach.

97. The surgeon usually takes an AP image and a lateral image during surgery. From the intraoperative fluoroscopy, one cannot tell that the screw was placed incorrectly. Interpreting the three-dimensional space using two-dimensional images is difficult; the surgeon must also use tactile feedback, and may use volt potential monitoring of the spinal cord, which reflects whether the spinal cord has been touched by the odontoid screw. Here, another doctor with expertise in the electrical monitoring monitored the patient's potentials; readings were at baseline throughout the procedure. The film shows bone on both sides of screw, in front and in back of screw. Dr. Levy testified that there was sufficient visualization to show alignment and purchase, and that if he were doing the surgery, with intact neurological stimuli, he would have been satisfied and would have closed. Respondent noted in the records that the surgery was successful. After surgery, the patient had movement in all extremities. But then, gradually over time, she started to lose that ability. At 6:04 p.m., the post-anesthesia care unit reported that the patient had difficulty breathing and called respondent. Respondent appeared at the patient's bedside a minute later and ordered a CT scan of the brain and cervical spine.

98. The postoperative CT showed that the tip of the screw was posterior to the odontoid, just touching the covering of spinal cord at a junction. The touching should not be enough to cause neurological changes. Respondent operated again to remove the screw. Once the screw was removed, the patient was still able to flex her extremities in response to pain.

Over the next day, her condition was stable until September 18 at 4:00 a.m., when a nurse noted that the patient was no longer responding to pain in the upper extremities. At 11:00 a.m., the patient had contracted hands, a sign of progressive neurologic dysfunction. Next, two MRI scans were obtained, documenting edema.

99. Nothing in the surgery was done incorrectly, and anterior surgery was indicated. Respondent's management of the patient by stabilization was within the standard of care; the patient refused to use the hard collar, so he switched to a soft collar. Stable anterior fusion outweighs the chance of fusion from longer use of the collar.

100. Though Dr. Levy was not asked to assess this prior to the hearing, he testified that the screw may have moved after the surgery. Postoperative movement of the screw is a well-known complication from this type of procedure; if the patient is moved aggressively afterward to bed, the head of the screw can move out anteriorly, and the tip will move posteriorly. Since there was no injury during Patient M.R.'s surgery, that might well have happened. Dr. Levy became progressively firmer in expressing his conclusion, opining that he was "absolutely positive" displacement after surgery and occurred outside of the operating room, when the patient was moved. During the surgery, there was no penetration of the dura, no blood, nothing at all to indicate intraoperative injury.

101. Respondent testified that he had ordered Patient M.R. a hard collar and instructed her to wear it, but she refused. He kept reminding her it was the best chance she had to heal without surgery, but she asked for soft collar, and respondent reluctantly acceded to her request, since he could not force her to use the hard collar. She ended up in the emergency room on September 16, 2013, complaining of nausea and dizziness and acknowledging continuing neck pain. A CT scan showed more displacement.

102. Respondent thought the placement of an odontoid screw was the best option, with the highest success rate in stabilizing the fracture line and the lowest morbidity. Respondent testified that he got a good alignment on x-rays and proceeded to operate. Based on the evidence available to him, i.e., x-rays, tactile feedback, and purchase, and intraoperative monitoring of the electric potentials indicating no injury to the spinal cord, respondent thought he had correctly placed the screw. Respondent left the operating room to dictate his notes, and the patient was extubated and taken to recovery. Several minutes later, the recovery room nurse said the patient was becoming weaker in her arms. Respondent observed Patient M.R.; he was very concerned about spinal cord injury and ordered a stat CT scan. The image showed the tip of screw behind, not in, the odontoid, abutting against the spinal cord. Respondent took the patient back into the operating room and removed the screw. He agrees with Dr. Levy, that something must have happened between the conclusion of surgery and his arrival in the recovery room. To cause a screw to shift in an elderly woman with frail bone, it is very conceivable that only a minor trauma or force to the head would be necessary. When respondent left her, she was on the operating table, wearing a hard collar. After surgery, a patient is then transferred to a gurney and wheeled to the recovery room, then transferred again, to a bed, so the patient is picked up and set down twice.

103. Complainant did not establish by clear and convincing evidence that respondent failed to obtain follow-up imaging to confirm adequate healing prior to terminating external immobilization in an elderly, osteopenic woman with a type 2 odontoid fracture. Complainant failed to establish that respondent departed from the standard of care when he failed to identify any intra-operative contra-indications to odontoid screw placement.

LEGAL CONCLUSIONS

Burden of Proof

1. The rigorous education, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proof of clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Dept. of Consumer Affairs, Bur. of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Applicable Authority

2. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, or have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

3. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, a violation of the Medical Practice Act, gross negligence, repeated negligent acts, failure to maintain adequate and accurate records of services provided to patients, dishonest acts, and creating false medical records. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2261, 2266.)

Causes for Discipline

4. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b), for engaging in gross negligence in connection with the care and treatment provided to Patients J.C., R.S., R.H., and G.V., but not in connection with the care and treatment provided to Patients M.M., W.C. and M.R., by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

5. Cause does not exist to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (e), for dishonest acts in connection with the care and treatment provided to Patients R.S. and M.M., by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

6. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in connection with the care and treatment provided to Patients J.C., R.S., R.H., and G.V., but not in connection with the care and treatment provided to Patients M.M., W.C. and M.R., by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

7. Cause does not exist to discipline respondent's certificate pursuant to Business and Professions Code section 2261 for creating false medical records in connection with the care and treatment provided to Patients R.S. and M.M., by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

8. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2266 for inadequate and inaccurate recordkeeping in connection with the care and treatment provided to Patients J.C., R.S., R.H., M.M., G.V., W.C., and M.R. by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

9. Cause does not exist to discipline respondent's certificate pursuant to Business and Professions Code section 2234 for general unprofessional conduct in connection with the care and treatment provided to Patients J.C., R.S., R.H., M.M., G.V., W.C., and M.R. by reason of Factual Findings 9 through 103 and Legal Conclusions 1 through 3.

10. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Accordingly, the Order that follows is both necessary and sufficient for the protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G 84650, issued to respondent Richard B. Kim, M.D., is hereby revoked. The revocation is stayed, however, and respondent's certificate is placed on probation for five years on the following terms and conditions:

1. Notification

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

3. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

4. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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5. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

6. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

7. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

8. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

10. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

11. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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12. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

13. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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14. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after respondent has successfully completed the clinical competence assessment program, respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and

education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

15. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's physician assistant supervision practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's physician assistant supervision practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that

responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

DATED: November 6, 2018

DocuSigned by:
Howard W. Cohen
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HOWARD W. COHEN
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Richard B. Kim, M.D.** **3501 Jamboree Road, Suite 1250** **Newport Beach, CA 92660-2939** **Physician's and Surgeon's Certificate No. G84650,** Respondent.	Case No. 800-2013-000428 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 26, 1998, the Medical Board issued Physician's and Surgeon's Certificate No. Number G84650 to Richard B. Kim (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2017, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of

the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2229 of the Code states, in subdivision (a):

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the

[1] Pursuant to section 2002 of the Business and Professions Code, the term "Division of Medical Quality" as used in the Medical Practice Act is deemed to refer to the Board.

applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct that would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent Richard B. Kim is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of seven patients. The circumstances are as follows:

Patient J.C.

10. On or about December 3, 2010, patient J.C., a 60-year-old right-handed male, presented for an appointment with Respondent with complaints of low back pain and lower

extremity pain. Respondent noted, "his back pain can go up to 10/10, randomly. The pain radiates down to both thighs, posteriorly into the hamstrings, calves and buttocks and it gets up to a 9/10." Patient J.C. also complained of bilateral leg weakness, numbness and tingling in his toes and feet. On physical exam, Respondent noted normal motor sensory and reflex findings. Respondent documented the results of an MRI (magnetic resonance imaging) as demonstrating L3-4 and L4-5 moderate central canal stenosis with associated bilateral foraminal encroachment at each of these levels and L5-S1 degenerative disease and spondylosis with moderate-to-severe left foraminal encroachment. Respondent's assessment was neurogenic claudication symptoms superimposed on degenerative lumbar spinal changes and spondylosis. He recommended a minimally invasive L3-4 laminectomy, discectomy and interbody fusion with bilateral screw instrumentation.

11. On or about January 11, 2011, patient J.C. did undergo an L3-4 minimally invasive laminectomy and transforaminal interbody fusion with percutaneous bilateral L3-4 screw rod placement. The procedure was without any complications and he was discharged on or about January 13, 2011.

12. On or about December 22, 2011, a follow-up MRI was performed. This demonstrated a new extruded right L4-5 disc fragment in the prior L3-4 fusion.

13. On or about July 13, 2013, a subsequent follow-up MRI was performed. It demonstrated the right L4-5 disc extrusion compressing the right L5 root and possibly the L4 root. It also demonstrated a small synovial cyst in the left L5-S1 facet joint with slight mass effect on the left S1 root.

14. On or about August 7, 2013, it appears that Respondent saw the patient for follow-up. The MRIs of December 22, 2011, and July 13, 2013, noted above were cited. Complaints of bilateral calf weakness were noted. Respondent recommended extending the fusion to the L4-5 and L5-S1 levels via an open procedure.

15. On or about August 22, 2013, patient J.C. was admitted and underwent surgery by Respondent. The operative report indicated that he performed L3, L4, L5 and S1 laminectomies for lumbar canal decompression, L3-L4, L4-L5 and L5-S1 bilateral foraminotomies for nerve root

decompression; L4-L5 posterior interbody fusion; thereby, accomplishing a fairly succeeding re-fusion via a single posterior approach at L4-L5 and L5-S1; L5-S1 posterior lumbar interbody fusion; removal of L3-L4 bilateral screw and rod hardware; placement of L3, L4, L5 and S1 bilateral pedicle screw and rod hardware; and L3 through S1 bilateral posterior fusion. In his operative report, Respondent noted, "DuraSeal was placed over the fusion material to hold it in place." On postoperative day 1 the patient was noted to have "right ankle dorsiflexion weakness as before surgery," per E. P., Nurse Practitioner for Respondent.

16. On or about August 24, 2013, a CT scan of the lumbar spine was performed. It demonstrated the right S1 screw traversing the right S1 neuroforamen and the right L4 screw lateral to the right L4 vertebral body and pedicle. The CT scan demonstrated that the pedical screw was malpositioned.

17. On or about August 26, 2013 at 8:17 a.m., in Respondent's first note after this initial surgery, Respondent documented a new right leg pain into the calf and sole of the foot, and an exam which showed, "stocking distribution partial numbness bilateral." He offered the patient either revision surgery or observation. The patient initially chose observation but then on the following day chose to proceed with surgery.

18. On or about August 27, 2013, patient J.C. was taken back to the operating room. Respondent documented that he repositioned the right L4 and right S1 pedicle screws. He noted that the dura was intact, yet once again stated that he used DuraSeal to hold the graft material together. Postoperatively, the patient's right lower extremity pain did resolve. There were no other documented complications; and, the patient was discharged on August 30, 2013.

19. On or about September 10, 2013, patient J.C. was readmitted with complaints of persistent drainage from the wound. Respondent documented in his admission history and physical, "the patient states that since his initial surgery he has had persistent drainage of fluid from his wound." The patient was also complaining of associated headache and was noted to have a fever of 100.9. On exam, he documented that the wound was without redness or swelling and that the patient was neurologically intact. Respondent over sewed the wound and started the patient on Vancomycin, Rocephin, ordered a CT and ordered interventional radiology to place a

lumbar drain.

20. On or around September 12, 2013, a lumbar drain was placed by interventional radiology. The cerebral spinal fluid (CSF) eventually grew enterococci. The patient's antibiotics were switched to Ampicillin based on sensitivities. On or about September 18, 2013, the drain was removed and J.C. was discharged.

21. In or around June of 2015, patient J.C. presented again to Respondent with complaints of neck pain, stiffness, left shoulder and hand weakness. He also had complaints of gait imbalance. Respondent noted 5/5 strength in his bilateral calves, normal sensation and decreased reflexes throughout.

22. Respondent subsequently documented an MRI from July 6, 2015, as demonstrating C4-5, C5-6 and C6-7 disc osteophyte complexes causing severe stenosis and cord compression with signal change within the cord at C4-5.

23. On or about July 16, 2015, Respondent performed a C4-5, C5-6 and C6-7 anterior cervical decompression via partial vertebrectomies and fusion on patient J.C.

24. In select follow-up visits between the surgery of August 22, 2013, and subsequent cervical spine surgery in July of 2015, Respondent does document exam findings of "bilateral calf weakness and gastrocnemius atrophy at baseline," minimal back pain and no leg pain. He documents that the patient is undergoing PT and has difficulty walking. In a note on September 9, 2013, he documents, "bilateral calf weakness, new spinal compression vs. diabetic neuropathy, others."

25. Taken individually or collectively, Respondent committed gross negligence in his care and treatment of patient J.C. when he:

(a) performed a spinal fusion without clear and documented indications;

(b) used DuraSeal dural sealant in spinal surgery in an FDA off label and highly unusual manner; and

(c) failed to expeditiously recognize and treat the malposition of a pedicle screw.

Patient R.S.

26. On or about August 29, 2012, patient R.S., a 61- year-old right-handed male,

presented with complaints of back and bilateral leg pain. Respondent noted that patient R.S. had failed conservative care, epidural steroid injections, and attempted synovial cyst drainage. Patient R.S. complained of back pain which he rated at 2-3/10 and leg pain which he rated at 4-9/10. Respondent noted a normal examination. Respondent interpreted an MRI as demonstrating L4-L5 spinal listhesis with disc protrusions, severe stenosis, synovial cyst, and a congenitally narrow canal. In fact, the MRI demonstrated moderate stenosis and disc degeneration, the patient had minimal grade 1 spondylolisthesis, there were degenerative changes at L5-S1 and the stenosis was worse at L4-5.

27. Respondent recommended L4-L5 decompression and interbody fusion with posterior instrumentation. A device would be surgically inserted at the L4-5 interspinous space. Respondent failed to pre-operatively document any applicable indications or rationale for performing fusion. First, there was no severe discogenic back pain. Instead, he documented that the back pain of patient R.S. was 2-3/10 which was bearable pain. Similarly, there was no evidence of instability. Respondent did not order any flexion or extension lumbar spine x-rays to establish instability. Next, Respondent could not justify performing a fusion in order to avoid a wide laminectomy including extensive facetectomy because he conceded that he typically performs decompressions through laminotomies.

28. Patient R.S. elected to proceed with the recommended surgery. On or about September 1 and 28, 2012, patient R.S. had two additional appointments with Respondent before his surgery. He was fitted for a brace.

29. On or about October 2, 2012, patient R.S. was admitted to the Hoag Memorial Hospital Presbyterian and taken to surgery. In the operative report, Respondent documented that he performed left L4-L5 hemilaminotomy, hemifacetectomy and foraminotomy for nerve root decompression; right L4-L5 hemilaminotomy and foraminotomy for nerve root decompression; L4-L5 transforaminal interbody fusion using Globus caliber graft; L4-L5 interlaminar stabilization with Paradigm Coflex clamp device.

30. In the description of the procedure, Respondent noted "first on the left side, a high-speed drill was used to drill off a portion of the lamina of L4 and the lamina of L5 and the entire

facet of L4. The remainder of bone and ligament were removed with Kerrison rongeurs....the same was done on the right side with the exception of facetectomy.....the intraspinous space was then prepared by clearing it out of soft tissue. The appropriate sized Paradigm Coflex device was then selected and capped into place. The rivets were placed and it was in excellent stabilization. A final x-ray showed good position of the construct."

31. There appear to have been three interoperative x-rays. At 10:50 a.m., a radiologist reported that the first x-ray, performed at 9:40 a.m., showed that a clamp was overlying the upper margin of L3. At 10:51 a.m., the same radiologist reported that the second x-ray, performed at 10:10 a.m., showed that a clamp was overlying L3 and L4. Several hours later, a different radiologist reported that the final x-ray demonstrated an L4-L5 fusion.

32. The next day, on or about October 3, 2012, patient R.S. was released from the hospital. A radiologist reported that day that an inpatient x-ray demonstrated an L4-5 interbody expander with posterior spinous process fixation L3 to L5.

33. On or about October 8, 2012, patient R.S. contacted Respondent. Patient R.S. complained of new postoperative left leg pain and urinary retention. Respondent recommended steroids and gabapentin. He also ordered a CT scan.

34. On or about October 9, 2012, patient R.S. received a CT. It demonstrated a Coflex device at the L3-4 interspinous space with no attachment to the L5 spinous process. The L4 spinous process appeared to be free floating secondary to the bilateral laminectomies and medial facetectomies.

35. On or about October 10, 2012, Respondent noted complaints of left leg lateral thigh pain 6-8/10, left leg weakness and frequent urination. Respondent's assessment was, "likely due to postoperative nerve irritation." He also assessed the urinary frequency as being "preexisting." (There is no prior documentation of patient R.S. having urinary difficulties or prostate problems.) He recommended referral to a specific urologist, a Medrol Dosepak, physical therapy and return for follow-up in one month.

36. A week later, on or about October 17, 2012, Patient R.S. followed up with Respondent once again. Respondent noted the incision had a reddish clear liquid. He noted that

the CT scan performed was "satisfactory." In fact, however, the CT demonstrated the Coflex device to be at the L3-4 interspace rather than at the L4-5 interspinous space. It also demonstrated that the remaining portion of the L4 spinous process was detached from the lamina; and, thus, essentially freely floating. There is no documentation in Respondent's office notes that he performed a wrong level surgery.

37. Subsequently, an MRI scan of the lumbar spine was interpreted as demonstrating postoperative fluid collection extending from L2 to L5 with some enhancement in the L3 spinous process.

38. On or about October 28, 2012, patient R.S. appears to have been hospitalized again. An L-spine series x-ray was performed. A radiologist interpreted it as demonstrating L4-L5 interbody implant, Coflex device from L3 to L5 spinous process and "subtotal resection of the L4 spinous process."

39. Four days later, on or about November 1, 2012, Patient R.S. was taken back for more surgery. Respondent's operative report from that date indicates that he performed: re-opening of lumbar wound and exploration of nerve roots; removal of L4-5 interlaminar clamp hardware; L4-L5 laminectomy and foraminotomies with nerve root decompression; L4 and L5 bilateral pedicle screw and rod fixation; and L4 to L5 bilateral posterior fusion. The discharge date could not be identified from the medical records.

40. In subsequent follow-up with Respondent, Respondent's notes indicate that patient R.S. had improvement of his left leg pain, persistent left leg weakness and persistent urinary retention. Respondent assessed patient R.S. as recovering well.

41. On or about November 21, 2012, patient R.S. had a postoperative visit with Respondent. In the postoperative visit note, Respondent documented that his reason for having to remove the Coflex device and place pedicle screws at the November 1 surgery was because at surgery a fracture of L5 lamina was found. Respondent documented that "[t]he clamp was removed, pedicle screws were placed."[2] Patient R.S. continued to have difficulties with urinary

[2] There is no documentation nor do any of these studies demonstrate an L5 lamina fracture after the first surgery and prior to the second surgery.

retention. He sought out a new urologist.

42. On or about February 4, 2013, patient R.S. had a follow-up visit. Respondent documented that the urinary retention had resolved and the catheter was out.

43. On or about July 11, 2013, patient R.S. received an MRI scan. The radiologist who interpreted it identified, "status post L4-L5 revision with widely patent central canal at this level; new L3-L4 retrolisthesis with stable L4-L5 anterolisthesis."

44. On or about July 12, 2013, during a hospitalization, another doctor ordered and patient R.S. received a CT scan of his lumbar spine without contrast. It was interpreted to demonstrate "status post resection of L4 spinous process and part of L3 spinous process. Status post posterior fusion at L4-L5 with intact fusion hardware; stable minimal anterolisthesis of L4 with respect to L3 and L5. Bilateral L4 pars defects or subacute factors, more evident on today's exam."

45. Taken individually or collectively, Respondent committed gross negligence in his care and treatment of patient R.S. when he:

(a) performed a wrong level surgery;

(b) performed a spinal fusion without acceptable indication;

(c) falsely documented and misrepresented an iatrogenic surgical error.

Patient R.H.

46. On or about October 24, 2012, patient R.H., a 76-year-old right-handed male, presented to an appointment with Respondent with complaints of right lateral hip pain of approximately one years' duration. He had undergone physical therapy, anti-inflammatories and two epidurals. He had also undergone drainage of a synovial cyst. He denied back pain. He had right buttock and lateral thigh pain that increased with walking. He denied numbness and weakness. His physical examination was unremarkable.

47. Respondent interpreted an MRI that had been performed at Hoag Hospital on October 10, 2012, as demonstrating severe mixed central spinal stenosis L4-L5 secondary to moderate disc bridge complex and moderate-to-severe facet arthropathy with an accompanying fibrotic synovial cyst of the right facet joint. In fact, the MRI demonstrated moderate stenosis and disc

degeneration. Patient R.H. had a minimal grade 1 spondylolisthesis. There were degenerative changes at L5-S1 as well. The stenosis was worse at L4-5.

48. Respondent recommended bilateral microdecompression at L4-L5 with interspinous clamp due to the mild listhesis. The records contain no documentation preoperatively citing any indications or rationale for fusion. No instability was established since no flexion or extension studies were performed. No back pain was present. Finally, although at an interview with the Health Quality Investigation Unit on September 1, 2016, Respondent tried to contend that a fusion was necessary due to the need to perform a wide laminectomy including extensive facectomy, imaging demonstrated that Respondent performed limited laminotomies only and Respondent conceded that he typically performed his decompressions through laminotomies.

49. On or about November 15, 2012, Respondent's note indicates that patient R.H. elected to proceed with the recommended surgery.

50. On or about November 27, 2012, patient R.H. was taken to surgery, which commenced at 7:50 a.m. and concluded at 9:56 a.m. Respondent's operative report indicates that he performed a left L4-L5 hemilaminotomy, accompanied by mesial facetectomy and foraminotomy; right L4-L5 hemilaminotomy, accompanied by mesial facetectomy and foraminotomy; L4-L5 interlaminar clamp for stabilization. He noted in his operative report, "an incision was made in the midline and posterior elements were exposed in a sub periosteal fashion bilaterally and x-rays showed this to be at the L3 and L4 level and so the incision was extended caudally to the next level and an x-ray confirmed that this was the L4-L5 level." At the conclusion of the operative report, he indicated that, "a final x-ray is pending." He indicated that he closed the wound. He dictated the operative report at 9:43 a.m. on November 27, 2012.

51. There are no progress notes in the documents provided by Respondent on November 27, 2012. A brief operative note was written by a nurse practitioner at 9:50 a.m. indicating that the surgery performed was an L4-5 interlaminar clamp placement. This note was subsequently signed by Respondent on December 17, 2015 at 9:18 a.m.

52. Intraoperatively, two x-rays were submitted for review. The first x-ray was performed at 9:03 a.m. on November 27, 2012, and was reported by a radiologist at 9:18 a.m. It was

described as a portable one view lumbar spine radiograph. The findings were reported as "instrumentation noted projecting over the spinous processes of the L3 and L4 vertebral bodies." A second x-ray was performed on November 27, 2012 at 9:32 a.m. In an interview with the Health Quality Investigation Unit on September 1, 2016, Respondent conceded that he misread the intraoperative x-ray. He blamed the mis-read on the poor quality of the image although the image quality was adequate and clearly demonstrated the interspinous clamp above the L4-5 level. The second x-ray was also described as a one view lumbar spine radiograph. It was reported by the same radiologist at 10:04 a.m., after Respondent had closed the wound, as demonstrating "a surgical device implanted in the L3 and L4 spinous processes."

53. Respondent noted on review of the final intraoperative x-ray that the interlaminar clamp was placed at L3-4 rather than at L4-5. He documented his review of that x-ray on November 27, 2012 at 2:39 p.m. He indicated that he discussed this finding with patient R.H. and R.H.'s wife and recommended returning to the operating room for repositioning of the clamp and additional decompression. PACU nursing notes indicate that Respondent was at the bedside of patient R.H. at 10:57 a.m. and stated that patient R.H. would need to go back into surgery and that the wife "will be informed." It is also noted that patient R.H. agreed at that time. Patient R.H. was consented for "re-opening and exploration of lumbar wound; possible repositioning of interlaminar clamp" at 2:57 on November 27, 2012.

54. On or about 3:40 p.m., patient R.H. was taken back to surgery which concluded at 5:09 p.m. Respondent indicates the procedure in his operative report as being, "re-opening of lumbar wound, removal of L3-L4 clamp and placement of the L4-L5 level with L4-L5 bilateral decompression." This procedure was without complications. Postoperative x-rays demonstrated the clamp at the L4-L5 level.

55. The remainder of patient R.H.'s postoperative course was uneventful. He was noted to be improved on postoperative day 1 with decreased pain. He was ambulating and he was subsequently discharged home. He continued to follow-up with Respondent over the course of the next approximately one year with repeat x-rays showing stable position of the interlaminar clamp. There were no further complications identified.

56. Taken individually or collectively, Respondent committed gross negligence in his care and treatment of patient R.H. when he:

(a) operated on the wrong level and misread an intraoperative x-ray prior to closing and concluding the case;

(b) performed a surgical procedure without clear and/or documented indications.

Patient M.M.

57. On or about March 26, 2012, patient M.M., a 54-year-old right-handed female, had an initial appointment with Respondent. Respondent noted complaints of low back pain and leg numbness which began on January 7, 2012. Patient M.M. was noted to have failed chiropractic care and treatment with gabapentin. She had low back pain which she rated as 6-9/10, right lateral hip and groin pain rated as 5-10/10, left buttock pain rated as 5-6/10 and left medial lower leg pain rated as 7-8/10 with walking. She also complained of right leg numbness, left medial lower leg numbness and weakness of the right leg. Respondent documented exam findings of "give way" weakness of the left ankle secondary to an Achilles tendon tear and decreased sensation throughout the right leg. Respondent noted an MRI which demonstrated L4-5 spondylolisthesis with intervertebral disc degeneration, disc protrusion, foraminal stenosis with compression of the nerve root and bilateral facet arthropathy. He recommended L4-5 decompression and fusion via a minimally invasive approach. Patient M.M. stated that she wished to proceed.

58. On or about April 5, 2012, Respondent performed the surgery. In his operative note he indicates that he performed a right minimally invasive laminectomy at L4-L5 and transverse lumbar interbody fusion with insertion of a Globus caliber cage. The operative note indicates that he tapped the cage past the anterior annulus, 1-2 cm. He could not pull the graft back and the applicator would not reseat. The graft was therefore left in place and expanded in its position. Respondent notes that the wound was dry; however, patient M.M. soon thereafter became hypotensive despite vasopressin treatment. Patient M.M. was resuscitated with blood plaques. A vascular surgery consultation was immediately called and a vascular surgeon subsequently performed a laparotomy and repair of the inferior vena cava and left external iliac artery, left the

abdomen open and applied a wound vac. Patient M.M. was noted to receive 9 units of blood during the course of these procedures. A subsequent operative note from the vascular surgeon on April 5, 2012 indicates that he removed the wound VAC and closed the abdomen.

59. As described, Respondent directly caused an injury to the inferior vena cava and iliac vessels during placement of the L4-5 interbody cage. There is no documentation that Respondent informed patient M.M. of the iatrogenic nature of the complication. In fact, thirteen subsequent postoperative office visit notes actually repeatedly indicate that the first surgery was aborted due to "medical complications." The common use of the term medical is misleading and appears to be an attempt to obfuscate the true nature of the complication.

60. Between April 20, 2012 and May 30, 2012, in subsequent postoperative visits, Respondent notes that he was unable to place the posterior screw secondary to "medical complications" from the first surgery. By May 16, 2012, Respondent had recommended that patient M.M. return to the operating room for placement of the posterior pedicle screws. Patient M.M. underwent a preoperative visit on May 30, 2012.

61. On or about June 5, 2012, patient M.M. underwent a second surgery. The intraoperative lumbar fluoroscopic view from the surgery shows only a lateral projection. It shows pedicle screw rod complex in L4 and L5 in the L4-5 interbody cage protruding well beyond the anterior borders of the vertebral body to 1-2 cm. It also reflects a mild grade 1 anterolisthesis of L4 on L5. Respondent failed to obtain an AP and lateral final fluoroscopic view which would have illuminated malposition of the left L4 and bilateral L5 pedicle screws, assuming that there were an adequate understanding of radiographic spinal anatomy.

62. Subsequently, Respondent's office visit notes fail to reference the second surgery that was on June 5, 2012. Also, within the course of the ensuing six months after the June 5, 2012, surgery, no less than five radiographic studies demonstrated malposition of the pedicle screws and in addition demonstrated a progressive listhesis indicating ongoing instability. Four of these studies were ordered directly by Respondent.

63. On or about June 25, 2012, patient M.M. underwent a CT of the abdomen. It clearly demonstrates malposition of the left L4 and bilateral L5 pedicle screws. Specifically, it

demonstrates a right L4 screw outside of the pedicle and lateral to the body traveling through the transverse process. It demonstrates the right L5 screw only halfway within the pedicle and outside of the vertebral body. It demonstrates the left L5 screw through the transverse process but outside of the pedicle and vertebral body. Also, the interbody cage appears to be protruding further out forward.

64. On or about July 23, 2012, patient M.M. underwent lumbar spine x-rays ordered by Respondent that show the left L5 screw to be inferior lateral to the left pedicle. The interbody cage remains in position halfway into the vertebral bodies. It shows worsening anterolisthesis since the last study.

65. Respondent's notes for patient M.M.'s office visits from July 23, 2012 and from August 29, 2012, fail to reference the x-ray results.

66. On or about September 5, 2012, patient M.M. underwent another x-ray ordered by Respondent. The report indicates a lateral position at least of the left L4 pedicle screw. It also indicates increasing anterolisthesis. Patient M.M. had an office visit with Respondent on the same day. The office visit is the first to acknowledge review of an x-ray. Respondent notes that the x-rays are "stable" despite the readings. It is unclear whether Respondent even reviewed these x-rays. A spine surgeon with an adequate understanding of radiographic spinal anatomy should have clearly noted malposition of the pedicle screws and combination with progressive listhesis should indicate ongoing instability and hardware malfunction. Additionally, patient M.M. was symptomatic and complaining of worsening back pain and radicular pain.

67. On or about October 29, 2012, patient M.M. had a follow-up visit. Respondent notes complaints of back pain and he recommends obtaining a CT scan.

68. On or about October 31, 2012, patient M.M. underwent a CT scan of the lumbar spine. This demonstrated a grade 1 borderline 2 anterolisthesis of L4 on L5 of 1.1 cm, which is significantly increased from before. It demonstrates the left L4 screw outside of the pedicle and the right L5 screw outside of the pedicle and only through the transverse process. It also reports lucencies around the screws. The report clearly indicates three of the pedicle screws in incorrect positions and significant progression of patient M.M.'s spondylolisthesis.

69. Patient M.M. had a follow-up visit on November 7, 2012. Respondent described the results of the CT as "stable." However, the CT demonstrates and the report indicates that there is malposition of several of the pedicle screws, significantly increased progression of the anterolisthesis and lucencies around the screws. Thus, use of the term "stable" is false and misleading. Once again, there is no documentation that Respondent recognized or informed patient M.M. that the screws were malpositioned and that patient M.M. remained unstable and would require revision or replacement to stabilize her spine. Instead he documents and recommends an open revision, complete laminectomy and reduction of the spondylolisthesis to perform a "more thorough fusion." Based on the manner of his documentation, it appears that he once again obfuscated the truth by implying that use of the minimally invasive approach precluded a thorough fusion. In reality, the minimally invasive approach had nothing to do with the failure of this surgery. At the time, based on Respondent's recommendation, patient M.M. elected not to pursue further surgery. Patient M.M. did eventually agree to undergo further surgery when informed by a different neurosurgeon of the true nature of her complication.

70. On or about January 8, 2013, Respondent failed to accurately document the malposition of the screws or to document that he informed patient M.M. of this surgical error. Instead, the documentation blamed it on "evidence of screw loosening." The screws were loose because they were not placed into the pedicles and vertebral body. There is minimal bone purchase through the transverse processes; and, thus, they quickly and progressively loosened over a short period of time.

71. In his interview of September 1, 2016, Respondent maintained that he did review the aforementioned radiographic studies, and did recognize the malposition. He justified the delay in recommending surgery to a lack of "extreme" symptoms, and the hope that patient M.M. might still fuse. However, when patient M.M. continued to have worsening symptoms, had he recognized the malposition all along, this should have been the basis to re-operate, rather than a need to do a "wider laminectomy." This false justification for repeat surgery, at the very least, belies his contention of recognizing the malpositioned screws, or proves a deliberate attempt to obfuscate his surgical error.

72. On or about January 9, 2013, patient M.M. had a follow-up visit. Respondent notes "progression of anterolisthesis and evidence of screw loosening." He recommends an open posterior re-do fusion and "extending the posterior fusion hardware from L3 to S1." He also recommends obtaining a bone density study and lower extremity EMG.

73. Taken individually or collectively, Respondent committed gross negligence in his care and treatment of patient M.M. when he:

(a) failed to recognize postoperative complications and /or expeditiously recommend appropriate treatment ; and

(b) used false, negligent and/or misleading documentation of surgical errors.

Patient G.V.

74. On or about February 4, 2013, patient G.V., a 55-year-old right-handed Caucasian male, presented with complaints of low back pain. He rated his low back pain as a 3-7/10. He also complained of left posterolateral hip and anterior thigh pain rated 1-7/10. Additionally, he complained of left leg weakness and dragging of his left foot. He had tried Vicodin, Morphine, physical therapy and several epidural steroid injections without satisfactory relief. His past medical history was significant for left L5-S1 laminectomy and discectomy on or about December 2, 2008, and a right L3-L4 laminectomy and discectomy on June 8, 2007. Respondent noted exam findings of left iliopsoas weakness of 4/5. His interpretation of an MRI performed on December 29, 2012, was of degenerative changes at L5-S1, L4-5, L3-4 and L2-3. L3-4 had the most severe changes with endplate changes and retrolisthesis. There was moderate-to-severe bilateral foraminal stenosis. Based on this, he recommended surgery in the form of L2 through S1 posterior lumbar interbody fusion with instrumentation from L2 through S1.

75. On or about February 19, 2013, patient G.V. underwent surgery at Hoag Hospital. He was hospitalized between February 19, 2013 and February 23, 2013. Respondent's operative report indicates that he performed L2 through S1 bilateral laminectomies, L2-3 through L5-S1 posterior lumbar interbody fusions, L2 through S1 bilateral pedicle screw rod instrumentation, and L2 through S1 bilateral posterolateral fusion with autograft and Actifuse. There were no complications noted in the operative report. An Intraoperative Note/Physiological Monitoring

Report dated February 19, 2013, does not document any evidence of significant abnormalities. The remainder of the hospital course appears uneventful; and, the patient was discharged on February 23, 2013 with pain medications.

76. Between March 13, 2013 and March 15, 2013, patient G.V. was re-hospitalized. He presented with headaches. He was worked up with a lumbar puncture. This showed a slightly low glucose of 32. He was diagnosed with aseptic meningitis "due to lumbar spine surgery." He was seen by Respondent, who placed him on Decadron. The headaches subsequently resolved. On or about March 15, 2013, patient G.V. was discharged.

77. In ensuing follow-up visits with Respondent between March 6, 2013, and February 19, 2014, there are no events or other significant complications noted. The patient is documented to have back pain that ranges 0-3/10 and improvement of his radicular symptoms and weakness.

78. Respondent committed gross negligence in his care and treatment of patient G.V. when he performed the February 19, 2013, surgery without clear indications and/or documenting those indications.

Patient W.C.

79. On or about February 1, 2012, patient W.C., a 76-year-old male, first presented to Respondent. He presented with complaints of low back pain which was worse with activity. He also had some posterior thigh pain which was mild. He had undergone physical therapy. Respondent documented a normal examination. He interpreted an MRI as demonstrating L5-S1 degenerative disc disease and an L4-5 protrusion with severe stenosis, mild stenosis at L3-4 and L2-3 with congenitally narrow canal. He recommended a minimally invasive transverse lumbar interbody fusion at L4-5 with pedicle screws from L4 to S1.

80. On or about February 9, 2012, Respondent performed surgery. His operative notes indicates that he performed an L4-L5 laminectomy, minimally invasive, with bilateral foraminotomies, L4-L5 transverse lumbar interbody fusion, L4 to S1, and pedicle screw rod fusion. There were no postoperative complications documented. The patient appears to have done well and was discharged two days later.

81. Subsequently, between February 22, 2012, and February 4, 2013, patient W.C.

followed up with Respondent.

82. On or about March 12, 2012, a fluid collection was noted at one of the incision sites. Respondent chose to observe. There is no further mention made of any fluid drainage.

83. On or about September 17, 2012, Respondent documented a new left foot drop that had begun over the last month. He indicated that an MRI could not be performed due to pulled retained K-wire fragment. There is no documentation of retained K-wire in his operative report. He noted the patient complained of low back pain in the SI joint area and having new left ankle weakness. He recommended a CT scan.

84. A CT scan performed on or about September 24, 2012, demonstrated the prior fusion and stenosis at L3-4. On or about October 15, 2012, Respondent documented that the CT showed no significant neural compression. He noted again the same amounts of left ankle dorsiflexion weakness. He recommended follow-up in three months.

85. On or about January 28, 2013, patient W.C. had a follow up appointment with Respondent. Respondent noted no significant events or recommendations.

86. On or about February 4, 2013, Respondent recommended continuing SI joint injections.

87. In September of 2013, the patient underwent L3-4 lateral interbody fusion coupled with posterior L3-4 pedicle screw rod instrumentation and L2-3 Coflex placement by another surgeon.

88. Respondent committed gross negligence in his care and treatment of patient W.C. when he performed the February 9, 2012, surgical procedure without clear and/or documented indication.

Patient M.R.

89. On or about June 8, 2013, patient M.R., an 83 year old female was seen by Respondent at the Hoag Hospital in Orange County after suffering a mechanical fall. CT imaging was performed. She had sustained what was then a non-displaced odontoid type 2 fracture, and C1 Jefferson's variant fracture involving the anterior and posterior arches. Respondent treated her non-operatively in a cervical collar for approximately 6 weeks.

90. After her release from the hospital, Respondent saw patient M.R. during outpatient follow-up clinic visits. After approximately 6 weeks of treatment with a cervical collar, without performing any follow-up imaging to establish whether she had healed the fracture, Respondent transitioned patient M.R. into a soft collar. Respondent later stated that he did not want to perform flexion-extension studies for fear of ongoing instability leading to a spinal cord injury during a flexion-extension study. Respondent also later stated that he recommended posterior C1-C2 fusion during outpatient follow-up clinic visits, but the patient refused surgery. No follow-up imaging was performed until patient M.R. subsequently returned to the hospital.

91. On or about September 16, 2013, patient M.R. returned to Hoag Hospital with complaints of nausea, dizziness, and continued neck pain. Repeat CT imaging of the cervical spine was performed. It was significant for increased widening of the C1 fracture lines, and newly noted superior distraction of the fractured odontoid to 0.5 cm. Respondent recommended surgery to patient M.R. and although not documented, Respondent later asserted that he had not only discussed odontoid screw placement with patient M.R, but, in fact, he had again recommended posterior C1-2 fusion but she elected for anterior odontoid screw placement despite his recommendation.

92. There are uncommon but highly consequential risks to this surgery. First, given the technical challenges of appropriate odontoid screw placement, screw malposition is a known complication of surgery. Additionally, given the position of the odontoid just anterior and inferior to the cervicomedullary junction and the cannulated k-wire technique of placement, unintentional penetration of the odontoid tip and injury to the cervicomedullary junction resulting in a cruciate paralysis (injury to the decussation of the corticospinal tracts in this region) is a known and potential complication of this procedure. Given these uncommon but highly consequential potential complications, meticulous technique with dual fluoroscopy and careful patient selection is critical to successful surgery.

93. There are also contra-indications to the surgery for odontoid screw placement. They include inability to reduce the fracture dislocation, kyphotic angulation, and a barrel-chested body habitus and osteoporosis. Appropriate screw placement requires the screw to be inserted just

under the anterior inferior lip of the C2 body and directed toward or to the tip of the odontoid process. Screw placement requires the fracture to be realigned with head position and/or external traction prior to screw placement. In order to achieve appropriate screw trajectory, a lordotic spine curvature is necessary and a barrel-chested body habitus is inhibitory. Patient M.R. was noted to have osteopenia. Respondent also indicated that patient M.R.'s alignment was kyphotic.

94. The next day, on or about September 17, 2013, patient M.R. was taken to the operating room and Respondent performed placement of an odontoid screw by an anterior approach. Per Respondent's operative report, there were no intraoperative complications. Respondent did note the trajectory of the screw to be "posterior," but he stated he was able to get across the fracture line, reduce the displacement, and had good screw purchase. Intra-operative neuro-monitoring was performed without any abnormal signals identified during the course of the surgery. Respondent later stated that intraoperative x-rays had been performed.[3] He also later stated that there had been difficulties but asserted that he had been able to achieve re-alignment.

95. Post-operatively, shortly after awakening from anesthesia, patient M.R. was noted to have become quadriplegic. A repeat CT of the cervical spine was performed and demonstrated that, "the screw does not traverse the dens, which is displaced anteriorly, but abuts the anterior aspect of the cervicomedullary junction." It showed that the odontoid was displaced anteriorly. Malposition of the screw with the tip extending beyond the posterior cortex of the C2 body was in a position sufficient to compress or injure the vertebrobasilar arteries and/or cervicomedullary junction leading to the brainstem infarction or contusion. Respondent took the patient back to the operating room and removed the screw.

96. The next day, on or about September 18, 2013, an MRI of patient M.R.'s cervical spine was performed. It demonstrated "interval development of new cord edema with associated restricted diffusion at the ventral aspect of the cervicomedullary junction likely at the site of prior screw fixation."

97. On or about September 20, 2013, an MR angiogram of the brain was unremarkable.

[3] However, no such films or reports were provided in the certified records produced to the Health Quality Enforcement Unit for expert review.

A repeat MRI of the cervical spine demonstrated worsening edema in the cervicomedullary junction consistent with evolving infarction.

98. Thereafter, patient M.R. remained quadriplegic and ventilator dependent. Given her advanced age coupled with the devastating brain stem infarction, her prognosis for meaningful recovery was low. Her family elected to withdraw support; soon thereafter patient M.R. died.

99. Respondent was grossly negligent when he failed to obtain follow-up imaging to confirm adequate healing prior to terminating external immobilization in an elderly, osteopenic woman with a type 2 odontoid fracture.

100. Taken individually or collectively, Respondent committed gross negligence in his care and treatment of patient M.R. when he:

(a) failed to identify any pre-operative contra-indications to odontoid screw placement; and

(b) failed to identify any intra-operative contra-indications to odontoid screw placement.

SECOND CAUSE FOR DISCIPLINE

(Dishonest Acts)

101. Respondent Richard B. Kim is subject to disciplinary action under section 2234, subdivision (e), in that he committed dishonest acts that were substantially related to his functions and duties as a physician and surgeon. The circumstances are as follows:

Patient R.S.

102. The facts and circumstances as alleged in paragraphs 26 through 44 are incorporated here as if fully set forth.

103. Respondent committed dishonest acts in his care and treatment of patient R.S. when he falsely documented and misrepresented an iatrogenic surgical error.

Patient M.M.

104. The facts and circumstances as alleged in paragraphs 57 through 72 are incorporated here as if fully set forth.

105. Respondent committed dishonest acts in his care and treatment of patient M.M. when

he falsely and misleadingly documented surgical errors.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

106. Respondent Richard B. Kim is subject to disciplinary action under section 2234, subdivision (c), in that he was negligent in his care and treatment of seven patients. The circumstances are as follows:

Patient J.C.

107. The facts and circumstances as alleged in paragraphs 10 through 24 are incorporated here as if fully set forth.

108. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient J.C. when he:

(a) performed a spinal fusion without clear and documented indications;

(b) used DuraSeal dural sealant in spinal surgery in an FDA off label and highly unusual manner; and

(c) failed to expeditiously recognize and treat the malposition of a pedicle screw.

Patient R.S.

109. The facts and circumstances as alleged in paragraphs 26 through 44 are incorporated here as if fully set forth.

110. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient R.S. when he:

(a) performed a wrong level surgery;

(b) performed a spinal fusion without acceptable indication;

(c) falsely documented and misrepresented an iatrogenic surgical error.

Patient R.H.

111. The facts and circumstances as alleged in paragraphs 46 through 55 are incorporated here as if fully set forth.

112. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient R.H. when he:

(a) operated on the wrong level and misread an intraoperative x-ray prior to closing and concluding the case;

(b) performed a surgical procedure without clear and/or documented indications.

Patient M.M.

113. The facts and circumstances as alleged in paragraphs 57 through 72 are incorporated here as if fully set forth.

114. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient M.M. when he:

(a) failed to recognize postoperative complications and /or expeditiously recommend appropriate treatment ; and

(b) used false, negligent and/or misleading documentation of surgical errors.

Patient G.V.

115. The facts and circumstances as alleged in paragraphs 74 through 77 are incorporated here as if fully set forth.

116. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient G.V. when he performed the February 19, 2013, surgery without clear indications and/or documenting those indications.

Patient W.C.

117. The facts and circumstances as alleged in paragraphs 79 through 87 are incorporated here as if fully set forth.

118. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient W.C. when he performed the February 9, 2012, surgical procedure without clear and/or documented indication.

Patient M.R.

119. The facts and circumstances as alleged in paragraphs 89 through 98 are incorporated here as if fully set forth.

120. Respondent committed negligent when he failed to obtain follow-up imaging to confirm adequate healing prior to terminating external immobilization in an elderly, osteopenic

woman with a type 2 odontoid fracture.

121. Taken individually or collectively, Respondent committed negligence in his care and treatment of patient M.R. when he:

(a) failed to identify any pre-operative contra-indications to odontoid screw placement; and

(b) failed to identify any intra-operative contra-indications to odontoid screw placement.

FOURTH CAUSE FOR DISCIPLINE

(False Medical Records)

122. Respondent Richard B. Kim is subject to disciplinary action under section 2261 in that he knowingly made or signed medical records which falsely represented the existence or nonexistence of a state of facts. The circumstances are as follows:

Patient R.S.

123. The facts and circumstances as alleged in paragraphs 26 through 44 are incorporated here as if fully set forth.

124. Respondent knowingly made false medical records regarding his care and treatment of patient R.S. when he falsely documented and misrepresented an iatrogenic surgical error on patient R.S.

Patient M.M.

125. The facts and circumstances as alleged in paragraphs 57 through 72 are incorporated here as if fully set forth.

126. Respondent knowingly made false medical records in his care and treatment of patient M.M. when he failed to document surgical errors in the medical records of patient M.M.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

127. Respondent Richard B. Kim is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of his services to his patients. The circumstances are as follows:

128. The facts and circumstances alleged in paragraphs 10 through 98 are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

129. Respondent Richard B. Kim is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct. The circumstances are as follows:

130. The facts and circumstances alleged in paragraphs 9 through 125 are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G84650, issued to Richard B. Kim;

2. Revoking, suspending or denying approval of Richard B. Kim's authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Richard B. Kim, if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 10, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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